Rocky Mountain Medical Journal

December 1951

Index Number

COLORADO AND WYOMING ANNUAL SESSION MINUTES

HEART DISEASE IN PREGNANCY — PHOTORADIOGRAPHY OF HEART

IRRITABLE COLON AS A COMPLICATION — THREE OTHER ARTICLES

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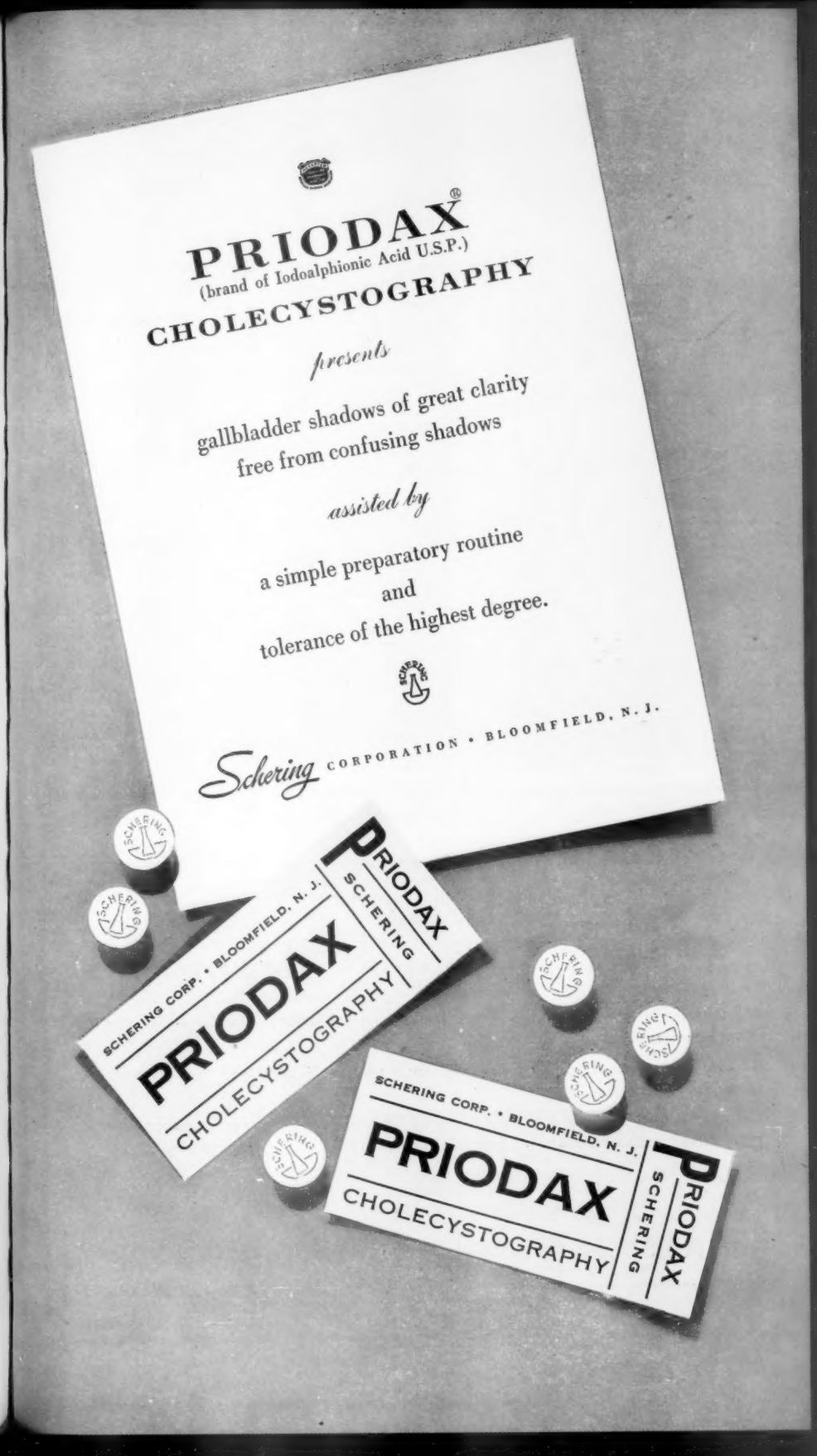
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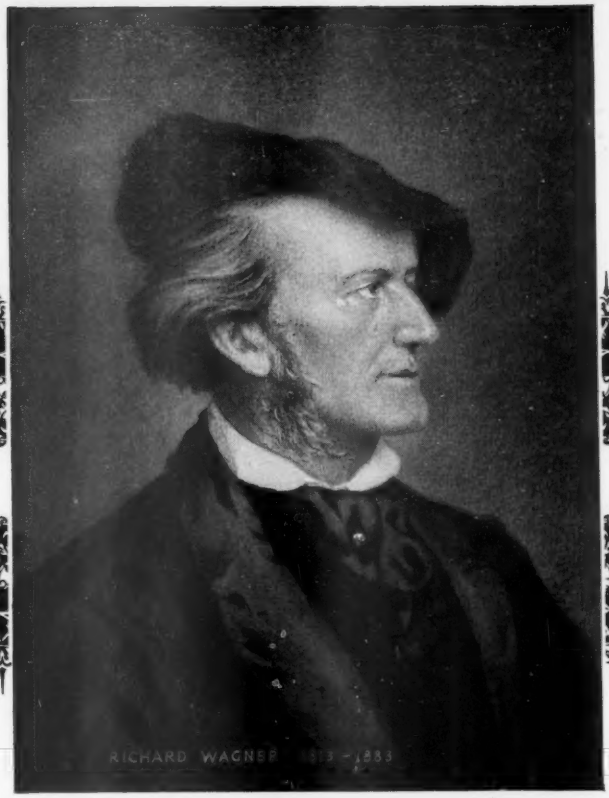

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NORM

Normal schedule of development (auxodrome) plotted on Wetzel Grid.[1]

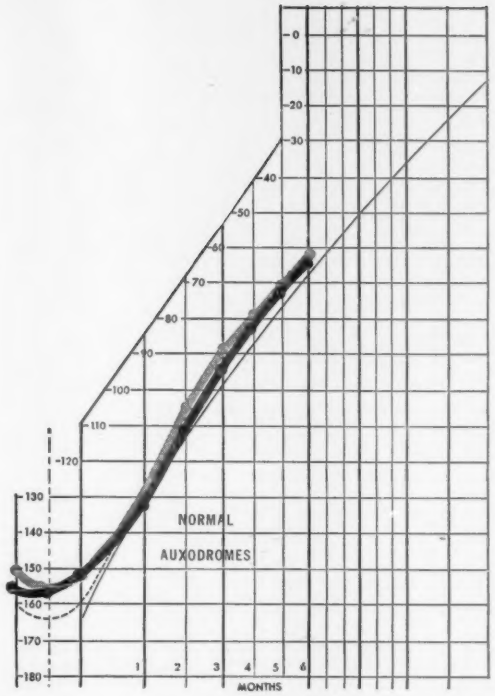
CURVE A

Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment;"[2] age: from birth to 6 months.

1. Wetzel, N. C.: J. Pediat. *29*:439, 1946.
2. Jackson, R. L., and Kelly, H. G.: J. Pediat. *27*:215, 1945.



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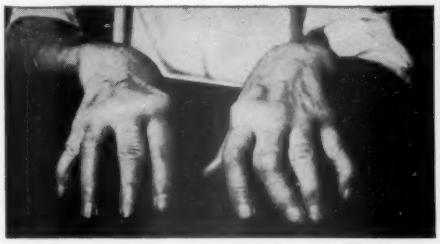

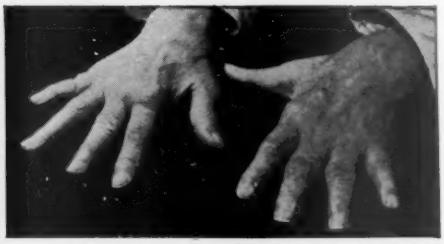

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References:

1. Chideckel, M.: M. Rec., 158:736, 1943. 2. Gordon, E. S.: Nutrition and Vitamin Therapy in General Practice, Year Book Publishers, Chicago, 1947. 3. Krehl, W. A. and Cowgill, G. R.: Food Research, 15:179, 1950. 4. Moore, E. L. et al.: J. Home Econ., 37:260, 1945. 5. Rafsky, H. A. and Newman, B.: Am. J. N. Sc., 201:749, 1941. 6. Rafsky, H. A. and Newman, B.: Geriatrics, 2:101, 1947. 7. Hoy, W. R. and Russell, R. E.: Food Industries, 20:1784, 1948. 8. Sedow, S. E.: M. Woman's J., 50:98, 1943. 9. Stephenson, W. et al.: Brit. M. J., 2:839, 1941. 10. Stieglitz, E. J.: J. A. M. A., 142:1070, 1950. 11. Thewlis, M. W.: The Care of the Aged, 5th ed., Mosby, 1940.

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1951

Editorial

State Editors' Conference Resumed by A.M.A.

ONE OF the important periodic meetings at A.M.A. headquarters was that of State Secretaries and Journal Editors. Complexity of organizational affairs has caused the conference to be omitted for the last three years. Secretarial problems have now been covered by other meetings, but editors were left more or less to manage their problems locally, without national consultation. State Journal editors had missed the national meetings and were pleased to join again at A.M.A. headquarters in Chicago last month to deliberate our problems. Apparently the conferences will now be held biennially.

State and regional medical journals are meeting increasing competition by specialty journals, a situation consistent with growth of specialization. However, general practice is again being emphasized by medical schools and is given a position of resumed dignity and importance in organizational activities and practice. Journals like our own are "on the spot" to maintain our essential position and to serve, in particular, our colleagues in general practice. A startling fact in medical journalism is that the Library of the Surgeon General in Washington receives about 7,000 different medical journals. They cannot all be leaders and many are of minor importance. State journals are not among the latter.

Editors, aided by personal inquiry and questionnaires, have concluded that readers prefer the following journal contents in order: First, clinical-pathological conferences and case reports; second, clinical reviews; third, original articles; fourth, editorials. Position of editorial choice is sad reality to editors who labor over these columns monthly. Reflection is not upon readers, but upon the editors. Editorials are designed to stimulate thought, to summarize views, and to discuss both sides of partisan and controversial subjects. They should inspire and develop new ideas, especially "hot" subjects, scientific and otherwise. Readers should be given both sides lest they be unaware that there are two sides. Local aspects of any national question should be emphasized. An editorial should be an opinion, not a report. Editorial columns are not the proper place for announcements, digests or partisan political news. The violation of sensible editorial policy explains our sad position in readers' choice, obviously our own fault. Ancillary trades and professions have been neglected. We have missed a lot of good will through more or less neglecting the dentists, nurses, technicians, druggists, and many others who serve and cooperate with us. Human beings are few who do not love to see their names in print. Therefore personal news and society news vitalize any regional journal. But how do we procure these items, especially those among us who serve the journal only as a hobby? We would be delighted to have more news items and will always place them in the proper section according to their respective states. Since we cannot seek them out individually, let us suggest that local editors, secretaries, and individuals send them in. In Rocky Mountain States, don't forget to send your copy to the editor for your own state rather than to our Journal's main office.

Book reviews should really be reviews. Too many are merely favorable or padded comments by someone who has scanned, but not read, the book. Favorable comment is always safe and is welcomed by author

and publisher, but not necessarily warranted. Remember that many fools aspire to write a book; many succeed—that is, in writing a book. Some authors have written to be read; some have hoped to make money; others aimed to teach; most have hoped to help their fellow man. The extent to which they have succeeded must be appraised by highest court, the readers. Sensible, honest, and critical reviews should constitute a first step toward classifying the work and placing it on the level where it deserves to be. When you send us a review, give us your personal analysis and unbiased appraisal, based upon critical study. Those who read your review will decide whether "it should be on the shelf of every physician interested in this subject" or whether "it will be an asset to the library of every physician." These quoted remarks have become cliches which belong in the permanent files with the old classic, "When I was in Vienna . . ."

There are not enough Letters to the Editor. Usually they appear only when we have made a mistake. Now and then the fumes from locker and cloakrooms should be gathered and composed, by those with strongest convictions, into a Letter to the Editor. Many pearls go up with the smoke and are lost forever. The Editor, no longer sensitive, would like to have all criticism whether it be favorable or not. We are not always right and, when wrong, would like to hear your side. Most of all, perhaps, it would be good to hear your voices, to note other styles of expression, and thus to animate these columns. More letters to editors would do as much as any one thing to move the editorial up from fourth place to, perhaps, second place in readers' choice.

About obituaries, there are too many. It is said that we are old when our minds make dates our bodies can't keep, and also when we scan the death notices first in the Journal A.M.A., noting the cause and age at death. The heart of a tired businessman was recently being sounded out by his conscientious family doctor. Said the latter, "Cut down on your golf; go to the office and relax!" There are probably no worthy physicians today who could follow such advice. However, at the risk of being trite, we might say relax, Doctor, and live to treat your patients over a longer period of time.

Original articles are always a gamble. State, not specialty, journals should be concerned with common things, and they should be brief. Note the popularity of digest magazines. The editor-in-chief of one of the larger national publishing firms has stated that he rarely sees an article or a book which could not be improved by shortening. Every medical journal editor will say amen to this. Most favorable readers' comments are directed to material which is brief, has "personality," and which has an introductory paragraph which explains what the article is all about and why it should be worth the readers' while to give it time, and which states by way of summary or conclusion what he has actually said—not merely that such and such has been reviewed or case reported. Original articles give a young physician a chance to establish identity provided, of course, that he has something to say. Again, editorial discretion must rescue readers from being afflicted by authors who do not have a message worthy of the time it takes to read it. Finally, scientific articles establish priority in original thoughts, research, and other work.

Material sent to us for publication should be specific, reasonably brief, and examples in experience and in cases should contain only positive relevant facts. Every successful author must cultivate the art of rewriting and shortening his material, perhaps many times. The secret of good publication is simplicity. The makeup of this and every other journal is composed of four fundamental ingredients: paper, type, ink—and ideas. We editors depend chiefly upon you, our readers, for ideas. Work upon them faithfully and critically; boil them down and shorten the material some more. Send them in through your own state editor. He and the rest of us at the headquarters office will do our best to sort, improve, perhaps constructively criticize and simplify, and publish material which will be a credit to you and to your Journal.

Original Articles

HEART DISEASE AND PREGNANCY*

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Although a discussion of this subject may belong more properly in the province of the internist, experience has shown us that the problem of what to do with the pregnant cardiac patient usually ends up in the lap of the obstetrician. Therefore, it is imperative that he have a clear understanding of the effect which a superimposed pregnancy can be expected to exert on a damaged heart. Although in some instances the combination of pregnancy and a cardiac lesion is something which we would like to avoid, with proper care and observation the vast majority of cardiac patients can be expected to tolerate pregnancy with little, if any, added risk so far as their life expectancy is concerned. We have observed a tendency for some internists to freely recommend interruption of the pregnancy when they are faced with a pregnancy in a cardiac patient. Our feeling is that termination of the pregnancy is rarely indicated under such circumstances.

This does not mean that pregnancy may not be a serious complication in a patient with a cardiac lesion. Heart disease ranks fourth as a cause of maternal mortality, being outranked only by puerperal infection, toxemia, and hemorrhage. On the other hand, it does not mean that motherhood should be denied the cardiac patient.

The problem of heart disease and pregnancy is primarily the problem of the pregnant patient with rheumatic heart disease. Most clinics report that about 95 per cent of their pregnant cardiacs have this combination. The other 5 per cent is made up primarily of patients with congenital heart lesions. What we will say now will apply primarily to the first group, although one clinic recently reported on a series of twenty-three pregnant patients with congenital heart lesions and concluded that there was no demonstrable difference between the clinical course of the patient with congenital heart disease and one with rheumatic heart disease, except in one respect. Over one-third of the patients with congenital lesions showed an increase in blood pressure during labor and a precipitous fall at the time of delivery, two patients actually going into deep shock without apparent obstetric cause. One of these two died in shock. This added possibility must be anticipated in dealing with the patient with a congenital heart lesion.

Although most patients now are aware of the presence of a cardiac lesion before they come into the hands of an obstetrician, not infrequently a rheumatic heart lesion has been first discovered during the course of a routine prenatal examination. This brings up the question of what should be the criteria for diagnosis of heart disease in the pregnant woman. Our experience in regard to interpretation of cardiac murmurs during pregnancy has been the same as that of most authors who have discussed this subject—namely, that there will be few mistakes if one never classifies as a cardiac in pregnancy any woman whose only sign of cardiovascular defect is the presence of a systolic murmur. If the murmur is associated with other signs such as cardiac enlargement, significant disorders of beat or signs or history of failure, further investigation is of course indicated. Systolic murmurs which disappear on change of position are so commonly heard during pregnancy as to be considered almost normal. The presence of a diastolic murmur, on the other hand, allows one to make a diagnosis of heart disease even in the absence of a history of rheumatic fever.

* Presented at Spring Clinic, Grand Junction, Colorado, March, 1951. From the Department of Obstetrics and Gynecology, University of Utah College of Medicine.

The next problem which confronts the physician, once the diagnosis of a cardiac lesion is made, is to attempt to set a prognosis as to what will happen to this heart during the course of pregnancy. We have found that the following factors are most important in attempting to set a prognosis in an individual case:

1. Age of the patient.
2. Duration of cardiac lesion.
3. Functional classification.

Of these three, the age of the patient at the time of the pregnancy seems to be of the most prognostic importance. A study of 103 cardiac pregnancies demonstrates this point very well[1].

DECOMPENSATION IN CARDIAC PREGNANCIES

Age	No. Cases	No. Decomp.	% Decomp.
Under 20	12	0	0.0
20-24	42	2	4.8
25-29	28	7	25.0
30-34	12	7	58.0
35-39	6	4	67.0
Over 40	3	3	100.0

Duration of the cardiac lesion follows along closely with the patient's age, inasmuch as 75 per cent of rheumatic infections have their onset prior to the age of 18. If there is a discrepancy between the patient's age and the duration of the heart disease, the latter should be given more weight in setting the prognosis.

The functional state of the heart as classified according to the American Heart Association has proved to be of great aid to us in setting a prognosis, and also in prescribing treatment during a pregnancy. An evaluation of the functional classification during the non-pregnant state is of aid, inasmuch as it has been shown that about 50 per cent will show advancement in symptomatology during the pregnancy-puerperal period.

CLASS ADVANCE IN RHEUMATIC HEART DISEASE OVER NON-PREGNANT STATE

Remained same	46 per cent
Advanced 1 class	32 per cent
Advanced 2 classes	15 per cent
Died	7 per cent
Decompensated	20 per cent

In this group of patients it was found that only one patient who was Class I in early pregnancy decompensated during the pregnancy, and this was due to the development of a subacute bacterial endocarditis.

It will be noted that parity of the patient is not an important factor in determining whether or not the patient is likely to decompensate during her pregnancy. Many studies have failed to show that the life expectancy of the female with rheumatic heart disease is significantly shortened by pregnancy. With careful handling the young patient with organic heart disease may be carried through pregnancy safely and show no evident shortening of her life expectancy for the cardiac disease because of the pregnancy. In the light of this statement, there will be very few instances in which interruption of a pregnancy will be indicated because of a cardiac disease. The question of sterilization of the cardiac patient is another problem. Particularly when the degree of cardiac damage involves the necessity of limitation of activities, it seems wise to preserve cardiac reserve for the reasonable care of a limited number of children. The rearing of children involves heavy cardiac work. Therefore we are liberal in offering sterilization to cardiac patients—not because we feel that in so doing we are increasing the life expectancy of the patient, but because we feel that the patient will be better able to care for the children she does have if she can avoid simultaneously carrying a pregnancy. There certainly is no justification whatsoever in recommending that a therapeutic abortion be carried out in a cardiac patient and not at the same time insisting that the patient be sterilized. There is no reason to assume that a cardiac patient will be in better condition to carry a pregnancy one or two years from now than she is at the present time.

Numerous cardiac tests have been proposed to aid in caring for the pregnant cardiac. Hamilton and Thomson in 1941 made the statement that "to date no satisfactory method of classifying poor from good risk patients with heart disease has been evolved by physiological studies of the circulation."

This statement still stands today. Measures of vital capacity and venous pressures, although they may corroborate clinical impression, are of little value in setting a prognosis. Determination of circulation time may be of more value, inasmuch as it is more directly a measure of left heart function. Blood volume studies at present are incomplete and of little practical value. All that has been shown to date is that during pregnancy there is a rise in the blood volume. The percentage of increase varies widely from month to month in the same individual and between different individuals. The use of physical signs is of some value. It has been found that cardiac enlargement is probably of the greatest prognostic significance. In the same group of cardiac pregnancies referred to above, it was found that no patient with less than a moderately enlarged heart decompensated during her pregnancy. Also many younger patients with moderately enlarged hearts did not decompensate. Auscultatory findings, although of aid in making a diagnosis, are of little aid in predicting the outcome of the present pregnancy.

We therefore come to the conclusion that the most important factor in determining what the outcome of any one cardiac pregnancy will be is the duration of the cardiac disease prior to the pregnancy. This will parallel to a large extent the age of the patient. Then if we can determine the functional classification of the patient at the time she began her pregnancy, we can, with proper care, prognosticate that the cardiac status will probably remain unchanged or advance one functional class during her pregnancy. There is no one cardiac test which will tell us which patient will decompensate. Careful clinical observation at frequent intervals alone will answer that question.

The prenatal care of the pregnant cardiac patient must emphasize prevention of cardiac failure and earliest possible recognition when it does occur. In order to do this, it is essential that all cardiac patients be given specific instructions regarding physical activity, rest, and recognition of symptoms suggestive of beginning decompensation. Our instructions to these patients are:

1. Budget physical exertion:
   a. Avoid shopping.
   b. Limit stair climbing.
   c. Reduce walking to a minimum.
   d. Nine hours bed-rest nightly and one hour bed-rest during the day.
2. Report at once if any of the following symptoms develop:
   a. Cough.
   b. Hemoptysis.
   c. Dyspnea.
3. Weekly examination with special attention to lungs. Persistent rales at lung bases first reliable sign of decompensation.

Not so long ago, it was the policy of many clinics to deliver their pregnant cardiac patients by cesarean section in order to spare the patient the ordeal of labor. During the last ten years there has not appeared in the literature one paper which recommends the use of cesarean section in these patients. In fact, many studies have shown that cardiac patients do better when allowed to deliever through the vagina. It is reasonable that the second stage of labor be shortened with the use of forceps whenever feasible, in order to spare the patient as much voluntary effort as possible. Few, if any, cardiac patients who are well-compensated prior to labor will decompensate during labor. In order to recognize the incipient decompensating patient as early as possible, the following routine is recommended for cardiac patients who are in labor: Pulse and respiratory rates are followed at fifteen-minute intervals. A persistence of pulse rate over 110 or respiratory rate of over 24 for three fifteen-minute periods is an indication for rapid digitalization. Sedation is always maintained slightly above that used in the normal laboring patient. During the second stage the patient receives a 50-50 mixture of nitrous oxide and oxygen during contractions and pure oxygen between contractions. Delivery is accomplished by low forceps extraction as soon as conditions are favorable, usually under saddle-block spinal anesthesia. The respiratory and cardiac check is continued every four hours on the day of and the

day following delivery. The first postpartum day is one of the most critical days of the pregnancy and should be subject to the same observation as during labor.

The problem of what to do with the decompensated patient who goes into labor is a vexing one. No matter what is done, the mortality rate will be high. Such patients are no candidates for major surgery. Their best chance lies in vigorous cardiac treatment during labor, delivery as soon as cervical dilatation is complete, and then prayer. There is no necessity to go into the details of the cardiac therapy here. That will be the same as for the non-pregnant female in a similar cardiac situation.

In conclusion then we can say that the old dictum which was first proclaimed by Peter in 1874, when he advised cardiac patients "not to marry, not to bear children, and if they did, not to nurse them" is untenable. If cardiac patients will marry early, have their pregnancies early, preferably before the age of 25, and limit the number to two or three, there is no reason why they should be denied the right of motherhood. Only one in ten cardiac patients under the age of 30 will decompensate during a pregnancy, whereas two out of three over 30 will decompensate. Parity per se does not affect the mortality rate of the pregnant cardiac, nor does it appear to shorten the duration of life.

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THE VALUE OF PHOTORADIOGRAPHY IN DETECTION OF HEART DISEASE*

FOLLOW-UP STUDY OF CARDIAC LESIONS FOUND IN A MASS (70mm.) X-RAY SURVEY

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Introduction

In 1946 it was estimated[1] that over twenty million Americans had had x-ray examinations of the chest. The figure would now probably approximate twenty-five million. The vast majority of these examinations were made by one of the miniature photofluorographic technics. These new x-ray technics have been a great step forward in discovering both tuberculous and non-tuberculous lesions of the chest. The value of these surveys in terms of better health is steadily increasing as more complete followups are made.

Since tuberculosis was the godfather and target of these surveys it is understandable that abnormal cardiac findings were disregarded in most of the earlier work. Now that the armed services, Veterans Administration, a few industrial concerns, general hospitals[2] and private clinics make miniature photoradiographs of the chest as a part of all routine examinations, more interest has developed in cardiac abnormalties. The number of articles listing cardiac lesions is still very small. Table 1 summarizes the findings of these authors.

TABLE 1
Articles Listing Abnormal Cardiac Findings

Author	No. Cases	Per Cent Abnormal Cardiac Findings	Type of Group Surveyed
McLean	34,918	4.1	67% under 20 years
Mark	40,000	0.7	general population
Gould	442,252	0.78	general population
Hodges	7,841	0.71	Clinic and hospital registrants
Robins	37,257	2.6	general population
Melamed	3,626	8.1	general hospital admissions
Hedburg	34,000	2.0	general population
Levitin	10,000	0.48	army inductees

*Presented at the Annual Meeting of the Colorado State Medical Society in Denver on September 21, 1949. From the Cardiac Clinic of the Colorado State Hospital, Pueblo, Colorado.

The only clinical follow-up study of cardiac abnormalties found in mass miniature x-ray surveys is the recent article by McLean and Rogan[3]. Their work from the Mass Radiography Unit in Glasgow was a follow-up of all who gave a history of rheumatic fever or heart disease as well as those showing x-ray abnormalties. Two-thirds of the group surveyed by them were under 20 years of age—a fact which greatly affects the type and per cent of heart disease found. These Scottish workers' follow-up showed considerable error by over-reading the miniature 35 mm. films. Out of 516 reported as showing "cardiac enlargement" only 93 proved to have organic heart disease. "Prominence of the pulmonary artery shadow" was reported in 418 but only 17 of these cases had heart disease. There is little wonder that their paper ended with this discouraging note: "The common radiologic patterns sometimes thought to be suggestive of heart disease are not, as a rule, associated with clinical signs of disease."

The results of our follow-up study are quite different from those of MacLean and Rogen.

Clinical Material and Procedure of Follow-Up

In June and July, 1947, the Tuberculosis Control Division of the Colorado State Department of Public Health conducted a mass x-ray survey of the patients at the Colorado State Hospital, using a 70 mm. mobile unit. Table 2 shows the number of patients x-rayed and the percentage suspected of having pulmonary or cardiac abnormalties. Six hundred and eighteen were not x-rayed either because they were confined to bed or were too disturbed.

TABLE 2
Mass 70 mm. X-ray Survey at Colorado State Hospital

	Number	Per Cent
Total number of patients x-rayed	4,079	.....
Number of x-rays suggesting pulmonary pathology	139	3.4
Active tuberculosis 35		
Inactive tuberculosis 62		
Suspicious of tuberculosis.. 42		
Number of x-rays suggesting cardiac pathology	101	2.5

TABLE 3
Follow-up of Patients With Abnormal Cardiac X-rays

	Number	Heart Disease Present	Heart Disease Not Present
Patients examined clinically	74	58	16
Dead and autopsy performed	16	16	0
*Dead but no autopsy	8	7	1
*Paroled	3	3	0
	101	84	17

*Clinical record reviewed.

Table 3 shows the type of follow-up of the 101 cases reported to have abnormal cardial findings on the 70 mm. film. The clinical records of the three paroled patients and the eight patients who died without autopsies were reviewed. Only one of these failed to show definite evidence of heart disease. The sixteen deceased patients on whom autopsies were performed all had heart disease. The remaining seventy-four patients were all examined in the cardiac clinc, and had standard (14x17) chest films and electrocardiograms. Each patient was seen by one of us and many of the patients were examined on several occasions. Table 4 first shows the type and number of cardiac abnormalities noted during the survey. "Left ventricular enlargement" accounted for 50 per cent of the find-

TABLE 4
Interpretation of 70 mm. Films and Comparison With Large (14x17) X-rays

Interpretation of 70 mm. Film	70 mm. Film	No. of Patients Having Lg. X-ray	No. of Lg. Films Confirming Diagnoses
Left ventricular enlargement	50	45	38
Left ventricular enlargement with aortic widening	3	3	2
Left ventricular enlargement with calcification of arch	1	1	1
Cardiac enlargement	17	17	15
Aortic aneurysm	1	1	1
Prominent aortic knob	2	2	2
Aortic widening	23	17	8
Aortic widening and sclerosis of arch	4	4	3
	101	40	70

ings, while aortic widening" and (general) "cardiac enlargement" make up another 40 per cent.

The second part of Table 4 is a comparison of the standard 14x17 films with the 70 mm. interpretations. The radiologic consultant reviewed all of the 14x17 films with us, when we were attempting to confirm or disagree with the 70 mm. diagnoses. Cardiac enlargement was determined by using Ungerleider and Clark's[4] table for expected heart size (transverse diameter) for patients with a certain height and weight. The greatest source of error in the small film interpretation was the report of "Aortic Widening."

The types of heart disease found clinically and at autopsy are shown in Table 5.

TABLE 5
Type of Heart Disease Found

	Clinical Examination	Autopsy
Hypertensive cardiovascular disease	31	1
Arteriosclerotic heart disease	20	8
Hypertensive cardiovascular disease and arteriosclerotic heart disease	4	3
Rheumatic heart disease	2	1
Congenital heart disease	4	....
Myxedematous heart disease	2	....
Myxedema and hypertensive cardiovascular disease	1	....
Thyrotoxic heart disease	1	....
Syphilitic aortic aneurysm	1	1
Syphilitic aortitis	1	....
Chronic cor pulmonale	....	1
Tuberculous pericarditis	....	1
Undiagnosed heart disease	1	....
No heart disease	17	....
	85	16

Hypertensive cardiovascular disease, arteriosclerotic heart disease or a combination of the two accounted for sixty-seven patients. Seventeen had no evidence of heart disease and the remaining seventeen were divided among the less common causes. The high percentage of hypertensive and arteriosclerotic heart disease found was to be expected with the age of the patients studied. Table 6 shows the age distribution of the patients in the follow-up series.

TABLE 6
Ages of Patients at Time of Mass X-ray Survey

Age	Number of Patients
20-29 years	2
30-39 years	2
40-49 years	8
50-59 years	16
60-69 years	30
70-79 years	25
80-89 years	16
90-95 years	2
	101

This follow-up study showed a high degree of accuracy in the interpretation of cardiac lesions found during the mass (70 mm.) x-ray survey. It was also of considerable help in locating cardiacs who needed treatment.

Comment

The value and feasibility of mass photoradiography has been established. The American College of Radiology[5], tuberculosis associations, the U.S.P.H.S. and other groups have committees working on further technical improvements and standardization of interpretation.

To include cardiovascular screening in these surveys the tempo will need to be slowed down[6] and certain changes will be desirable. Thompson and Jellen[7] listed the following sound suggestions:

1. That height and weight be routinely recorded during mass surveys for pulmonary tuberculosis.

2. That great care be used in centering the subject.

3. That films not be interpreted as far as the heart is concerned when rotation is present, when there is pericardial fat which cannot be clearly identified as such, or when the cardiac borders are obscured by cardiac or respiratory motion.

4. That it be clearly understood many cases of cardiovascular disease will not be detected by the use of survey films alone.

5. That a diagnosis of heart disease not be made on the basis of survey films alone, and that suspected cases be studied clinically and by the use of standard 14x17 inch teleroentgenograms made at the end of quiet inspiration.

6. That it be realized the radiologic method is not suitable as the sole method for conducting a case-finding program for heart disease, but that it will find some cases of heart disease as a by-product of surveys made primarily for tuberculosis.

These authors found that when using 4x5 inch films if the transverse diameter is measured in millimeter and multiplied by 3.7 this figure can be used with Ungerleider and Clark's tables.

Aside from prevention one of the laudable trends in modern medicine has been the organized efforts to detect potentially serious diseases when still asymptomatic or mild in nature. Thus we have had surveys for tuberculosis, cancer detection drives, and soon will have diabetic detection week.

Except for rheumatic fever clinics and venereal disease clinics no such programs have yet been instituted for heart disease, the leading cause of death in our country.

Although little has been written on the benefits of early detection of heart disease many teachers in this field have pointed out the value of diagnosing heart disease in the asymptomatic stage so that this period may be prolonged or if their heart trouble is one of the "curable types" specific measures may be instituted.

No one method of detection, of course, will suffice but mass or routine photoradiography offers another valuable and feasible way to attack this problem.

Summary

The statistical reports of many mass x-ray surveys have listed the number or percentage of abnormal cardiac findings, but almost no follow-up studies have been made of these cases. Miniature (70 mm.) x-ray films were made of 4,079 patients at the Colorado State Hospital in July, 1947. One hundred one of this group were reported to have abnormal cardiac findings. These patients were examined in the Cardiac Clinic, had electro-cardiograms, and large (14x17) chest films made. The great majority of these patients were found not only to have "heart trouble" but to be in need of some type of cardiac treatment. These surveys should be utilized more in the detection of heart disease, as well as pulmonary lesions, in both civilian and hospital populations.

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CHRISTMAS MAIL

The following is reprinted from the Postal Bulletin of November 1, 1951, at the request of the local post office:

Greeting Cards—Send holiday greetings as first-class mail to obtain the many advantages which this service affords. Such greetings prepaid at the first-class rate may be sealed and contain written messages; they are dispatched and delivered first; forwarded, if necessary, without additional charge, and, if undeliverable, returned at no further expense to the mailer provided the sender's return address is shown on the envelope.

Unsealed Christmas greetings sent as third-class mail without unauthorized writing enclosed are chargeable with 2 cents postage (if weight does not exceed 2 ounces). However, a minimum charge of 3 cents is applicable to such greeting cards which measure less than 4 inches long or 2¾ inches wide.

Patrons having a number of greeting cards to deposit are urged to tie them in bundles with addresses all faced one way before mailing so as to facilitate their handling in the post office.

Greeting cards bearing particles of glass, metal, mica, tinsel, and other similar substances for decorative purposes which are likely to rub off and injure postal employees or damage canceling machines must be enclosed in tightly sealed envelopes with postage prepaid at the first-class rate in order that such cards may be accepted for mailing.

THE DIAGNOSIS AND MANAGEMENT OF RHEUMATIC FEVER*

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It has been an often-quoted statement occurring in most textbooks and articles on rheumatic fever, that the disease is most prevalent and most severe in temperate and cold climates, and wherever the weather is cold, wet and changeable, rheumatic fever thrives. In addition, the statement that has been most emphasized has been that the disease flourishes in those climates which have an abundance of streptococcic infections. However, it has been well proved in recent years that rheumatic fever flourishes in all climates—at least in all areas in the United States—in the tropical and sub-tropical as well as the cold and temperate areas.

The nature of the illness and its sequelae make studies of incidence, diagnosis, and treatment important and desirable. Rheumatic fever, with complicating cardiac disease, is a more frequent cause of heart difficulty, both in children and adults, than any other cause. It is almost the only form of chronic heart disease occurring in children under 14 years of age, other than congenital heart disease.

The etiology of rheumatic fever has been, and still is, controversial. Many theories have been advanced from that of a specific organism to hypersensitivity. It is now conceded that a role is played in its causation by repeated infections of the beta-hemolytic streptococcic group, although recently the dramatic success obtained by Hench, Kendall, and others with cortisone and ACTH in rheumatic conditions makes it appropriate to consider the possibility of other etiologic factors. Thus it may be essential that we revise our concept of this disease, if preliminary studies done only in a few cases are borne out by future observations on enough cases to warrant amending the literature.

The seriousness of rheumatic fever has made it mandatory for pediatricians and cardiologists, public health officials and educators, to study all ramifications of the disease in order more carefully to tabulate its occurrence, symptoms and prevention. From the standpoint of incidence little is known in many areas because the disease is not reportable; even in areas where reportability is ordered, such reports are frequently not made.

Diagnosis of rheumatic fever offers a challenge to the observer because of its protean nature. Its manifestations are systematic and may be associated with acute carditis, acute polyarthritis, chorea, myalgia, and insidious carditis. Early diagnosis is demanded because of the disabling nature of the disease, so that appropriate treatment may be instituted and morbidity and mortality reduced. In the figures of Jones, used as a standard from a ten-year study of 1,000 cases of rheumatic fever, indications are that only 25 per cent escape some permanent disability from the disease, while another 25 per cent succumb to it. This leaves one-half with residual cardiac damage. Of these, one-sixth are totally incapacitated and one-sixth are, for all practical purposes, completely well, while two-thirds of the remainder are permanent cardiac cripples. There is no exact information or method available that would permit evaluation of what early diagnosis and essential treatment would do in such cases. Forward-looking programs with standard diagnostic and treatment centers, with state subsidies for hospital and convalescent care, such as is prevalent today in many states, will go a long way in helping this situation.

Deaths from heart disease under 40 years of age are almost entirely due to rheumatic heart disease. Therefore, we can assume that rheumatic fever contracted in childhood is reflected in the cardiac deaths up to 40 years, particularly. These estimates are sufficient to prove that heart disease in children, which is largely rheumatic, con-

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stitutes an overwhelming public health problem. Among school children only, heart disease is the fourth cause of death in the United States. Various estimates place the number of cardiacs in the United States at from 2,000,000 to 3,000,000, and in addition it is well established that there are approximately 1,500,000 rheumatic fever cases in the United States today, and that about fifteen of each 1,000 school children have some form of heart disease. This percentage not only applies along the Atlantic seaboard of the United States and the Rocky Mountain States, but also California and the southern states as well. The incidence of heart disease has increased 45 per cent in the past fifty years; whereas, the incidence of tuberculosis has declined 50 per cent. This contrast is largely due to the better and more widespread dissemination of knowledge concerning tuberculosis, its diagnosis and treatment. In rheumatic fever, we have a disease which is on the increase, and that should serve as a challenge so that the irreparable loss of hours and economic losses due to the disease may be reduced. This problem is a grave one, not only from the standpoint of economics, but from the the standpoints of morbidity and mortality.

From the standpoint of diagnosis, it is not always easy to arrive at a decision as to whether a patient has rheumatic fever. This is particularly true in some areas in the country, particularly in my own state, where we have, I am convinced, a milder, more insidious type of disease than in some other areas. In a typical case, however, there is nearly always a history of nose and throat infections of a streptococcic type, two or three weeks prior to the onset, then a latent period during which there is convalesence from the acute infection, at which time there is a slow onset of temperature ranging from 99 to 100 and sometimes higher in the fulminating cases up to 103; pain in the muscles and joints, swelling, redness, tenderness may all be present, especially in knee, wrist and elbow joints. One of the most common symptoms that occur in nearly all cases are spontaneous nosebleeds, unassociated with nasal pathology. Abdominal pain is so frequently a symptom and it may simulate appendicitis so closely that frequently the initial diagnosis is that; in fact, in a series of cases studied at the University of Minnesota Hospital by Dr. Stoesser, it was found that at least 25 per cent of the cases which had an entry diagnosis of acute appendicitis, had a discharge diagnosis of acute rheumatic fever. Other symptoms in the mild insidious cases are failure to gain weight, irritability, failure to make progress in school, poor appetite, easy fatigue and malaise. The duration of the initial attack may be from two to three weeks, and may range from two or three weeks to several months. Remissions and flare-ups are common, and the disease is likely to be chronic and recurrent. It is necessary to differentiate certain things in children, particularly, from the standpoint of diagnosis. Tuberculosis, especially bone tuberculosis, may simulate rheumatic fever closely, as may also osteomyelitis and certain nutritional diseases as scurvy and rickets. Infantile paralysis is not uncommonly mistaken for rheumatic fever in its earlier states. It is important that you not only carefully evaluate and observe the symptoms that I have mentioned, but that certain other observations and laboratory procedures be carried out. There is no specific laboratory procedure which will help make a diagnosis of rheumatic fever. However, there are certain findings that are indicative and corroborate the diagnosis. Increased white blood counts are usual; there is nearly always a mild secondary anemia; the blood sedimentation rate is increased; pulse rate is usually increased, and the blood pressure may be slightly elevated and of some value. Electrocardiographic tracings, except for showing a mild tachycardia in many cases, are not diagnostic.

In management of rheumatic fever, active treatment should be divided into four stages:

1. Treatment of the acute disease.
2. Treatment during the subsiding stage.
3. Convalescent treatment.

4. Management of quiescent rheumatic fever.

In planning management of the acute stage, it is always essential to acquaint parents with its chronic nature and the possibility of recurrence, and that the period of treatment will not cover a few days, but months and years.

In spite of new advances in the field of antibiotics and chemotherapy, the most important and essential treatment of acute rheumatic fever is rest. Additional treatment is usually symptomatic therapy. In the subsiding stage, the important things are diet and restriction of activity. In the convalescent phase, diet and gradual increased physical activity, and in the quiescent stage, observation and prevention of recurrent infections. It is essential to evaluate the state of activity of the infection in passing from one phase of therapy to the other. In order to do this, all information available must be correlated and utilized—history, physical examination, and laboratory studies. Obviously, if a child has fever, tachycardia, pain, choreiform movements, enlarged heart, subcutaneous nodules, erythemas, anemia, and definite electrocardiographic abnormalities, there is no doubt but what the infection is active, and that complete bed rest of the patient is an essential part of treatment. It is true that following the acute attack, if there is a definite gain in weight in the child, appetite is good, blood count and color have improved, if the temperature and sedimentation rate are normal, there is little doubt that the process is no longer active and the child can be permitted more activity and a more normal schedule.

The great trouble is in the mild case of rheumatic fever frequently seen in some sections of the country. In those cases, at no time do the symptoms become exceedingly severe and, at most, there is only a slight elevation of the sedimentation rate, a slight anemia, an occasional nosebleed, lack of appetite, failure to gain weight, and low grade temperature. These cases are active, should be treated as such, and are often overlooked. All these cases should be seen at regular intervals, even after activity has subsided. In addition to strict bedrest in acute phases, there are definite things that may be valuable in treatment. Salicylates are well proved; even though an old treatment, it has been revived in recent years and is now invaluable in relief of symptoms in early stages of the illness. Dosage of sodium salicylate or acetylsalicylic acid should approximate one grain per pound, although with the introduction of para-aminobenzoic acid in its combination with sodium salicylate, the dosage of the salicylate can be reduced approximately one-half and you can still maintain the salicylate blood level that is essential. Don't overlook the possibility of salicylate poisoning in administering large dosage. Acidosis may develop before symptoms of salicylate poisoning which occur later, such as vomiting. Other things of value besides rest, proper diet, and supportive measures are sedation. I have found barbiturates to be most helpful, and the dosage can usually be kept at a low level. The average child will do very well on one-fourth grain of phenobarbital three times a day. It is wise to keep in mind, too, here that occasionally even phenobarbital will cause a skin rash or some untoward effect. Recently we have been using in addition a drug called Tolserol, valuable for pain from muscle spasm and other conditions. Dosage has ranged from three and one-half grains four times a day in small children, up to fifteen grains four times a day in older children. In the subsiding stage, while bed rest should still be maintained as long as there is evidence of fever, tachycardia, increased sedimentation rate, further attention must be paid to diet which must be liberal in iron and vitamin supplements. Here the added factor of emotional and psychologic management enters in.

Diversional therapy is important in this stage. A good occupational therapist can help work out mild play activities while in bed and, later, simple tasks as weaving, clay modeling, drawing, etc. In the convalescent stage of the disease it is wise to establish a positive schedule, definitely

stating how much time should be devoted to each effort in the beginning. The best place to have a child with rheumatic fever in the convalescent stage is a convalescent hospital, because here the patient and the parents can be indoctrinated into the things essential in management. Emotional and psychologic attitudes of patients and parents are exceedingly important.

The most important recent advances have been in the field of prophylaxis. It has been thoroughly established that hemolytic streptococci infections which incite rheumatic fever may be prevented. Most of us have had considerable experience in administration of either sulfamerazine or sulfadiazine or penicillin (oral), given throughout the year to children who are known to have recurrent infections of that type, and therefore might be susceptible to rheumatic fever, or where there is a family history of rheumatic disease. Also, this methods is of value in preventing recurrence of rheumatic fever in cases which are quiescent. The dosage that I have used has been one-half gram of sulfamerazine and 100,000 units of penicillin daily during the entire year. Naturally, in these cases the physician has the responsibility of watching for possible toxic effects of the drugs. This requires that during the first month, weekly examinations of blood and urine should be done. Toxic manifestations are exceedingly rare. In my own office my associates and I have had a group of 300 such children on sulfa prophylaxis for the past five years. Reactions from either penicillin or sulfa drugs will occur in the first four weeks if they are likely to happen. After that period, monthly examinations only are required.

It should be positively stated that none of the antibiotics or sulfa drugs have any value in the actual treatment of rheumatic fever but, on the contrary, may do real harm and not prevent an attack after the inciting streptococcic infection has begun. In any discussion of rheumatic fever, the question of removal of foci of infection as tonsils, teeth, etc., always comes up. Much controversy has arisen as to the prophylactic value of removal of tonsils and adenoids from the standpoint of prevention of rheumatic fever. I am sure that the same indications for correction of infections exists in a rheumatic patient as in an otherwise normal child. Such surgery should not be done during the acute, febrile stage of the disease, but during the quiescent stage, and such surgery should always be accompanied by adequate penicillin or sulfa therapy. The average case of rheumatic fever should be kept under observation closely, at least at monthly intervals for five years, since 80 per cent of recurrences occur during that time, the ratio of such recurrences before and after fifteen years being five to one. It may be safely said that regarding the entire problem of rheumatic fever at this time, the following points should be emphasized:

1. The etiology of rheumatic fever is not entirely known, but that over all the years there has been a specific role played by the hemolytic streptococcus.

2. That the dramatic success of Cortisone and ACTH opens up a new field of research and probably treatment in the disease.

3. That an early diagnosis, especially in the many mild cases which are now often missed, is extremely important in the management of the disease, not only from a medical, but also from a public health and economic standpoint.

4. That there is still no specific drug or biotic therapy in the disease, although Cortisone and ACTH have promise.

5. That the prophylactic use of penicillin and sulfa has proved valuable in preventing recurrences and keeping down streptococcic infections.

AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1952 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of $1,000, and the essay will appear on the program of the 1952 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1952. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Massachusetts.

THE IRRITABLE COLON AS A COMPLICATION OF DISEASE OF THE GALLBLADDER AND PEPTIC ULCER*

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One of the commonest conditions which the gastroenterologist is called upon to treat is the "irritable colon" syndrome. Its recognition and importance as a complicating factor in producing symptoms in patients with disease of the gallbladder and peptic ulcer are often overlooked, however, until it is brought to our attention by patients who come to us with the complaint, "I had my gallbladder removed but I still have my old symptoms." Furthermore, there is the group of patients who have been treated with what is usually an adequate medical regime for duodenal ulcer but because of persistence of gastrointestinal symptoms, the ulcer is thought to be intractable to medical therapy and they are consequently advised to have surgical treatment.

The diagnosis and treatment of the irritable colon have been previously outlined by the senior author and will not be considered here. It is the purpose in this paper to re-emphasize the importance of the irritable digestive tract as an associated complicating factor in these two diseases and to stress the fact that this condition must be recognized and adequately treated if the patient is to obtain the relief from his gastrointestinal symptoms which should be expected from skillful technical removal of the gallbladder or an adequate medical regimen for the ulcer.

The need for cholecystectomy is well recognized today. With increased use of this operation the need for accuracy in diagnosis and for the use of every measure to effect good end results has become increasingly important. The old axiom, "the belching female of fair, fat, and forty has gallbladder disease" can no longer be considered factual and the dictum that gallstone disease is the commonest cause of abdominal dyspepsia and gaseousness has likewise been proved false. In our experience, the commonest cause of gaseous dyspepsia is not gallstone disease even though the patient has gallstones; it is aerophagy or colonic and small intestinal dysfunction. In our opinion there is no so-called medical gallbladder. In the experience of the Lahey Clinic, four conditions in the gallbladder require surgical intervention. In the order of their frequency of occurrence they are: (1) cholecystitis with stones; (2) acute sometimes gangrenous cholecystitis without stones; (3) papillomas of the gallbladder and (4) carcinoma of the gallbladder. Approximately 80 to 90 per cent of patients submitted to cholecystectomy for cholelithiasis with a history of typical attacks of biliary colic experience satisfactory results, whereas not more than 50 to 60 per cent of patients subjected to cholecystectomy for so-called chronic noncalculous cholecystitis with dyspeptic symptoms and without a history of biliary colic experience satisfactory results. In our opinion, the preoperative diagnosis of disease of the gallbladder, even though the history and radiologic findings are definite, should be made only after a careful survey of the rest of the digestive tract. Such conditions as achlorhydria, diverticulosis, irritable colon and, of course, an ulcer, should be determined preoperatively. All these conditions are frequently found in association with gallbladder disease, and it is of great importance to know of them preoperatively, not only because certain of these conditions require special preoperative care but also because the postoperative management of the cases is such a potent factor in effecting satisfactory end results. Before the patient is operated upon the nature of the presenting symptoms should be carefully analyzed to determine what proportion of the total subjective picture is due to the presence of gallstones and what proportion is the result of these other abnormalities which may be present. Obviously, none of these conditions will be cured by cholecystectomy alone.

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The Graham-Cole test has been of incalculable value in the diagnosis of disease of the gallbladder. For practical purposes, two diagnostic criteria are considered essential: (1) failure of the gallbladder to fill with the dye, and (2) consistent appearance of irregular shadows, either radiolucent or opaque, within the gallbladder wall. Orally administered dye can be considered a satisfactory test only if it shows a normal gallbladder or definite shadows of stones, but intravenously administered dye should always be used as a check if there is nonfilling of the gallbladder. Nonvisualization of the gallbladder with the dye indicates failure of absorption of the dye or failure of function of the gallbladder. However, it is most important to distinguish between functional failure due to organic disease in the gallbladder itself and failure due to a temporary cause, probably spasm of the sphincter of Oddi, which is relieved when the cause outside the gallbladder is corrected. Such a cause may be an acute duodenal ulcer or, more commonly, an acute irritable digestive tract; following relief of this condition the previously nonfilling gallbladder may be normally visualized. At the Lahey Clinic faint filling and slow emptying are considered of little importance unless associated with opaque or radiolucent shadows indicating stones. The less definite findings usually are the result of functional disturbances or possibly of a mild inflammatory process in the gallbladder from which recovery on a medical regimen is possible. The work of Ivy and his colleagues on the physiology of the biliary tract has shown experimentally what has been confirmed by experience clinically—that the gallbladder with its bile reservoir and pressure regulatory mechanism is associated intimately with the function of the duodenum. Specifically, his results show, among other things, the effect of duodenal irritation and irritability upon the tonicity of the sphincter of Oddi, and the production by the latter of dilatation of the common duct and the occurrence of pain. While the tonicity of the sphincter of Oddi is decreased after cholecystectomy, it may later become abnormally increased and again cause dilatation of the common bile duct with resulting right upper quadrant pain. In such an event, the symptoms experienced before cholecystectomy may be reproduced. Since duodenal irritability and irritation may be the basic causes of such recurrence of pain, it becomes necessary to seek their causes and to administer appropriate treatment. Duodenal irritability may be the result of localized duodenitis, duodenal ulcer, or even more frequently part of a generalized gastrointestinal irritability, so often the cause of digestive symptoms. This syndrome is the cause of many of the symptoms of chronic dyspepsia so often ascribed to disease of the gallbladder with which it is frequently associated. Duodenal irritability by its effect on the function of the gallbladder may conceivably play a definite part in the stasis of bile within the gallbladder to which Ivy stated the formation of gallstones may well be ascribed. Certainly, cholecystectomy does not cure an irritable digestive tract and the symptoms so often ascribed to gallbladder disease will return unless the irritable digestive tract is treated after operation. Secretory abnormalities such as achlorhydria or hyperchlorhydria should likewise be considered in the postoperative regimen. The period of postoperative convalescence after cholecystectomy can be ideally utilized to the best advantage of the patient and with the greatest ultimate satisfaction to the physician if all digestive abnormalities receive intensive treatment. Only those relatively few patients with a history of attacks of typical gallstone colic, in whom the pain and vomiting are obviously the result of transient hypertonicity of the sphincter and dilatation of the ducts with associated pylorospasm and in whom the digestion between attacks is entirely normal, should be treated by cholecystectomy and routine postoperative care. In our experience the corollary of the above is equally true, namely that neither the acute nor chronic peptic ulcer nor the irritable colon can be treated satisfactorily by medical management in the presence of gallstones. Even in those cases in which there have been no attacks of gallstone colic but only the symptoms

of irritable colon or of ulcer, cholecystectomy should be done if gallstones are demonstrated, in order to procure the best results from ulcer or bowel management, as well as to avoid the complications of cholelithiasis.

Another observation valuable to us is the fact that, in cases of cholelithiasis in which the operation is postponed for legitimate reasons, the dietary management best adapted to the avoidance of gallstone colic need not be the traditional fat-free diet but may include some fat, provided it is not in the form of fried foods. Normal amounts of cream and butter, if included in an otherwise easily digestible diet, are entirely innocuous and may be included in small quantities in the diet of the patient treated preoperatively for obesity. These fats may also be included in the postoperative diet of patients with disease of the gallbladder. The stimulation of cholecystokinin by acid-fat contact with the intestinal mucosa need not be avoided if duodenal irritation can be prevented, and this is best accomplished by the use of bland, easily digestible food employed in the treatment of the irritable digestive tract.

There are several reasons why studies to exclude the possibility of duodenal ulcer are often required in patients suspected of having colonic or intestinal dysfunction. First, the two disorders coexist in so many patients, and it is important for the practitioner to keep in mind the frequent occurrence of symptoms of an irritable colon in addition to those caused by the duodenal ulcer. Second, duedenal ulcer occasionally produces pain in one of the lower abdominal quadrants rather than in the epigastrium. Third, not infrequently the irritable colon syndrone is associated with epigastric pain which may be relieved by the taking of food. This duodenal ulcer-like symptom in some patients with intestinal and colonic dysfunction evidently is the result of the concomitant neuromuscular irritability in the pyloro-duodenal area.

Many writers have stressed the occurrence of this epigastric pain simulating somewhat the pain of duodenal ulcer in patients with the irritable colon syndrome. Typical rhythmic duodenal ulcer-like distress, however, is not often produced by colonic dysfunction. If a classical history of duodenal ulcer is obtained, objective examination usually demonstrates an ulcer. However, a history of pain of the same character, but lacking the classical rhythm and periodicity of the ulcer pain, is obtained often enough to make it of diagnostic importance. The irritable colon frequently causes the symptoms of bloating, belching, indigestion and nausea so frequently ascribed to the ulcer, which has in reality responded well to the prescribed medical therapy. Likewise, whereas milk is the sheet anchor of ulcer therapy, it frequently aggravates symptoms of colonic instability. In fact, food of any kind, by initiating the gastrocolic reflex, is likely to make colonic symptoms worse. The characteristic distress of the irritable colon, in addition to lacking the classical rhythm and periodicity of duodenal ulcer, is transient, shifting in nature, of variable occurrence and may be relieved by rest, heat or passage of flatus or feces. It is typically aggravated by fried foods, raw fruits and vegetables, emotional tension and cathartic abuse.

Summary

The purpose in this paper has been to reemphasize the frequent association of irritable colon, disease of the gallbladder and peptic ulcer and the great importance of recognizing and treating by appropriate therapy the symptoms of colonic dysfunction when they complicate the clinical picture of gallbladder and peptic ulcer disease. The importance of accurate diagnosis of disease of the gallbladder before submitting the patient to cholecystectomy is also emphasized along with the diagnostic pitfall of accepting faint filling and slow emptying of the gallbladder with the Graham-Cole test as being indicative of organic disease of the gallbladder.

OBSTETRIC ANESTHESIA — 1951

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Obstetric anesthesia has progressed from the elementary stage of chloroform dropped on a handkerchief to a scientific maze of closed inhalation systems, caudals, and spinals. No single type will suit all cases. Today the well-trained obstetrician must be prepared to offer the anesthetic indicated by the psyche of the patient, by the type of delivery anticipated, by the systemic and obstetric complications arising and by the fetal emergencies encountered.

The author reviewed 413 consecutive anesthetics used in vaginal deliveries during a residency period in a small hospital. A primary aim here was to substitute block anesthesia for routine general anesthesia where possible. Careful analysis of these few cases proved interesting in light of indications or contraindications, advantages or disadvantages, satisfaction and complications.

In Ten Years

Scanning the literature for the past decade we find caudal was introduced, tried, tested and proved in many clinics. An editorial printed in J.A.M.A. during 1943 gives an excellent survey of this method: "The technic is one which demands the competent art of the specially trained anesthetist or surgeon and the practice of a high order of obstetric science. It is not a method for the indiscriminate use in the home or by those who have not been especially trained in its technic or in a realization of conditions which might contraindicate its use."

Saddle block likewise was introduced, tried, and tested and has become popular in many hospitals. Likewise, with block anesthesia becoming popular, pudendal block has been used more and more with success in the hands of some operators. J. P. Greenhill in Chicago feels this should receive more widespread usage, while Boston Lying In Hospital reports excellent results using general anesthesia in 80 per cent of their cases.

These Methods

Our caudal technic consisted of inserting a No. 16 caudal needle into the canal, inserting a No. 4 laquored catheter through the needle and removing the needle. Metycaine 1.5 per cent solution was used exclusively, 10 ml. being injected as the test dose followed in ten or fifteen minutes by 20 ml. Caudal was used for the most part as delivery anesthesia only, rarely as continuous caudal. Criteria for administration were early crowning in primiparas and engaged head with 7 cm. dilitation in multiparas.

Saddle block technic differed not at all from standard methods. Heavy nupercaine (2.5 mg./ml.) was utilized in dosage varying from 1.0 to 1.4 ml. Regular spinal needles were used, 20 or 22 gauge, the latter preferred.

General anesthesia at this hospital was given by nurse anesthetists. Nitrous oxide and oxygen with ether as necessary were usually used. Drop ether became emergency anesthesia for rapid cases. The Chief of Anesthesia felt conditions did not warrent safe usage of cyclopropane because of the rather old physical plant.

Pudendal blocks were by customary methods, using 1 per cent procaine solution, with or without epinephrine.

As to Incidence

Examination of Chart 1 shows incidence of various types of anesthesia used in 413 cases. If the agent used was not adequate entirely for delivery, it was classed as a failure. Of the ten caudal failures, five were due to the operator being unable to insert a needle into the caudal canal, of which two were credited to extreme obesity. Two patients delivered, requiring GOE, before they could get relief from caudal anesthesia. One patient with an extreme curvature of the sacrum obtained fundal relief but no perineal relief. The operator felt in one case he was in the caudal canal, but as no relief resulted, this failure must be attributed to missing the

CHART 1

	Caudal	Saddle	Pudendal	GOE	Ether	Total
Primary choice	235 (56.9%)	113 (27.3%)	5 (1.2%)	50 (12.1%)	10 (2.4%)	413
Primary adequate for delivery	225	107	3	50	10	395 (95.6%)
Secondary anesthetic used	1	4	0	12	2	19
Secondary adequate for delivery	1	3	0	12	2	18
Total successful anesthetics	226 (95.7%)	110 (94.0%)	3 (60%)	62 (100%)	12 (100%)	413

canal. The tenth case dripped spinal fluid from the caudal needle and the procedure was halted. She shortly received a satisfactory saddle block.

Seven cases receiving saddle block were classed as unsatisfactory. Two of these had partial relief, insufficient for delivery but adequate for perineal suturing. Three failures came from administration of the block too far in advance of the patient being ready for delivery. One failure came when an intern could not find the subarachoid space, and another resulted while experimenting with the double-needle technic. The discrepancy in total figures in columns 3 and 4 resulted from one case, a caudal failure when the canal was missed, and a saddle failure in the same patient due to blocking two and one-half hours prior to delivery. She delivered under GOE.

Pudendal block gave little satisfaction in our series. Two of the five women required inhalation anesthesia and a third (classified a success) suffered pain during delivery. In the remaining two cases, relief was adequate for delivery and repair.

This Indicates

Chart 2 lists the indications for the various types of anesthesia. The physician advised a block for his patients where possible, but few patients actually expressed a choice of anesthesia. The majority who did (seven out of twelve) desired general anesthesia. Various complications of pregnancy which indicated one or another type of agent speak mainly for themselves, but a few bear comments. The staff was divided on anesthesia for breech deliveries; some preferred general, others block. Breech presentation often is considered a contraindication to a block, but the author feels where a spontaneous or assisted breech delivery can be anticipated, saddle or caudal offer the preferred anesthetic. Regional anesthesia has been proved time and again to be choice for premature infant delivery. Our figures show four of thirteen cases received GOE because labor was too rapid to permit a block. Most patients with precipitous labors will require

CHART 2

Reason for anesthetic choice	Caudal	Saddle	Pudendal	GOE	Ether
Doctor's choice	201	85	3	2	0
Patient's choice	2	3	0	6	1
Twin pregnancy	2	1	....	....	....
Breech presenting	8	2	1	6	....
Brow presenting	....	1	....	....	....
Face presenting	1	....	....	....	....
Deep transverse arrest	1	....	....	....	....
Premature infant	5	4	....	(+4)	....
Prolapsed cord	1	....	....	....	....
Rapid labor	1	14	....	24	....
				(—4)	....
Abruptio placenta	1	1	1	....	....
Pre-eclampsia	1	1	....	....	....
Elderly primipara	3	....	....	....	....
Arrested tuberculosis	....	1	....	....	....
Cardiac disease	2	....	....	....	....
Diabetes mellitus	1	....	....	....	....
Pyelitis	1	....	....	....	....
Abdominal-perineal resection	1	....	....	....	....
Previous cesarean	2	....	....	....	....
Previous myomectomy	1	....	....	....	....
Uncooperative patient	....	....	....	1	....
Saddle failure	1	....	....	5	1
Caudal failure	....	4	....	5	1
Augment pudendal block	....	....	....	2	....
Doctor unavailable for block	....	....	....	11	6

general anesthesia (twenty-seven out of forty-two). We found saddle block very useful in such cases, provided time permitted its administration.

The prolapsed cord occurred just at full dilitation in a multipara twenty-five minutes after beginning a satisfactory caudal. She was promptly delivered by Kielland forceps rotation and delivery from ROP position, the infant surviving. One case, a 37-year-old primipara, had a permanent colostomy following a combined resection for carcinoma of the rectum. Caudal gave her excellent relief for low forceps delivery and repair of central episiotomy.

CHART 3

Deliveries	Caudal	Saddle	Pudendal	GOE	Ether
Spontaneous	43 (20%)	14 (14%)	2 (50%)	28 (58%)	9 (75%)
Low forceps	146 (69%)	72 (71%)	2 (50%)	17 (35%)	3 (25%)
Rotations	12 (6%)	8 (8%)	....	....	....
Mid forceps	11 (5%)	8 (8%)	....	3 (6%)	....

Increased Aid

Table 3 compares spontaneous deliveries with low and mid-forceps deliveries and rotations under various anesthetics. Percentages compare favorably between saddle and caudal blocks. If one practices the "Newer Obstetrics" mentioned by George Kamperman, he expects to perform low or outlet forceps in a majority of cases. Considering under Chart 2 that GOE was used predominantly where rapid labor or the immediate absence of a physician to administer a block accounted for 58 per cent of these anesthetics, this tempers the marked predominance of spontaneous deliveries under general anesthesia. The author feels block anesthesia increases the incidence of posterior positions. Such anesthesia is given when the presenting part reaches the perineum or even sooner in multiparas. If one waits for anterior rotation, this is so often followed by prompt delivery that block anesthesia would be out of the picture. Perineal relaxation combined with loss of sensation to push tend to hinder natural rotation once block has been given. We must also remember the percentage of cases in which it is not possible to recognize fetal position until sterile vaginal examination is made at time of delivery. These cases, already blocked, are rotated and delivered.

There Were Complications

Chart 4 lists complications attributed to anesthesia. Fall in blood pressure exceeding 20 mm. systolic was considered significant, and occurred in 4 per cent of caudals and 10 per cent saddle blocks. Associated sign of fetal anoxia (drop of fetal heart rate below 120) occurred in four of the nine caudals and seven of the eleven saddle blocks with hypotension. Thus, drop in pressure and concurrent fetal distress were both more prevalent with saddle block. One case of headache followed caudal, but the author does not feel this should be attributed to the anesthetic. Our incidence of spinal headaches was 11 per cent. One should say the type of anesthesia did not affect the incidence of retained placenta in this small series. Pilonidal cyst, operated or not, must be considered a contraindication to saddle or caudal. Our two cases, one operated upon and one not, received caudal, but in both instances the scar and sinus were situated well cephalad of the caudal canal. Relief was excellent with no aftereffects in either case. Although the author was the anesthetist in both these cases he does not endorse the procedure. One of our two cases where saddle block was repeated developed headache. With our small series postpartum hemorrhage occurred in 2: 226 caudals, 1: 62 GOE's—a greater incidence for the latter but too small a number of cases to be significant. Failures in block anesthesia are discussed elsewhere.

Two cases bear discussion, both wives of physicians. The patient developing tremors was a gravida 3 para 2 who was poorly medicated (100 mg. demerol five hours before caudal). Tremors of all extermities developed one-half hour after the final dose of 20 ml. metycaine was given. Her pressure fell slowly in that thirty minutes from 110/70 to 70/40, but there was no fetal dis-

tress. Ephedrine sulfate was given by injection. The author feels better sedation including barbiturate might have prevented these tremors. Outcome of this case was entirely satisfactory. The other case, a successful saddle block with 1.2 ml. nupercaine, discharged on postpartum day 7, returned on the following day after having one convulsion at home. This was believed due to cerebral irritation from leakage of spinal fluid aggravated by enforced dehydration for suppression of lactation. Intravenous fluids were administered on readmission without recurrence of convulsions.

CHART 4

Complications	Caudal	Saddle	GOE
Fall in blood pressure	10 (4%)	11 (10%)	....
Associated fetal distress	4	7	....
Headache	1 (0.4%)	12 (11%)	....
Retained placenta (spontaneous)	1	....	1
Retained placenta (manual)	2	2	1
Pilonidal sinus or scar	2	....	....
Tremors	1	....	....
Convulsions	....	1	....
Incomplete relief	7	8	....
Incomplete relief (required GOE)	3	4	....
Complete failure	6	2	....
Block repeated	....	2	....
Postpartum hemorrhage	2	....	1

Critical Analysis

Now let us analyze these case reviews under light of our original aims: Advantages, indications, satisfaction and complications. With our small series of cases we demonstrated caudal and saddle blocks could give satisfactory anesthesia in a high percentage of cases (95 per cent). Our evaluation of pudendal block (60 per cent successful) cannot be judged fair on so few cases, but our rules were stringent—either an anesthetic agent gave adequate relief for delivery or it was a failure. The fact that so many clinics augment their pudendal blocks with general anesthesia makes the author believe their results are not wholly satisfactory either. General anesthesia can be counted upon definitely for relief of pain. This 100 per cent reliability remains a strong selling point for these agents, as does their availability and ease of administration.

As it must be in so many hospitals, the doctor selected the type of anesthetic in a large percentage of our cases. Certainly this is as it should be, but possibly the patient's desire should be given more attention in uncomplicated cases. Assuredly, most deliveries may be managed safely by any of the anesthetic agents available, but certain problems contraindicate certain types. Pulmonary or cardiac diseases contraindicate general anesthesia, particularly inhalation types. States of shock contraindicate saddle or caudal blocks. As a general rule, difficult forceps operations proceed more easily with the increased soft-tissue relaxation under caudal or saddle block. A premature infant should indicate block anesthesia.

Spontaneous deliveries can be effected with block anesthesia. The incidence of forceps deliveries is greater with caudal and saddle blocks than general anesthesia or pudendal blocks. Our forceps rotations were done entirely under blocks, bearing in mind as we explained in the text that a block may increase the persistence of a posterior vertex. We far preferred block anesthesia for mid-forceps deliveries (86 per cent).

Frank inspection of the chart on complications makes one ask himself, "Are caudals and saddles worth while?" Hypotension and fetal anoxia develop in a small percentage. Spinal headaches cause profound complaints. Tremors, convulsions, incomplete relief or total failure must be constant problems facing the anesthetist. Fetal depression, laryngospasm, vomiting and aspiration of vomitus after general anesthesia counterbalance these problems somewhat. The joy of a mother at seeing and hearing her baby immediately after birth brings tremendous satisfaction to a physician, enough to make block anesthesia first choice in most of his cases.

Let us as obstetricians establish certain aims in anesthesia. First, let us try to please

the patient by discussion of the anesthetic means at hand, offering her a choice of general or block anesthesia. Second, we must be ever cognizant of pre-existing contraindications or developing complications forbidding the use of certain anesthetic agents. Lastly, we must familiarize ourselves with technics of block anesthetics and be on constant guard to better general anesthesia methods for our patients.

Conclusions

1. Anesthetics used in 413 consecutive vaginal deliveries were critically reviewed.

2. Caudal and saddle blocks gave excellent anesthesia in a high percentage of cases, but complications were frequent.

3. General anesthesia offers 100 per cent reliability, availability and ease of administration.

4. Patients free from complications should be permitted to express their choice of available anesthetics.

5. Obstetricians must stand prepared to use the anesthetic indicated in a complicated case.

A PLAUSIBLE TREATMENT OF RHEUMATOID ARTHRITIS*

By ADRENO-NEPHRO-COLOPEXY

O. S. FOWLER, M.D.
DENVER

Of the numerous methods of treatment of rheumatic arthritis, perhaps bed rest for months has been best—rather than all kinds of drug therapy. The key to this might be partial orthostatic restoration of various organs affected by general splanchptosis in the upright attitude of the body, particularly kidneys and adrenal glands. We all know that five minutes of rest lying down is worth more than ten minutes sitting upright. Thus our first ancestor who assumed the upright position did, in many respects, an anatomical disservice to his descendants, even though it did help to develop the hand and brain.

The hormonal system is probably the most complex biochemical mechanism in the human body. It took God and a few hundred million years of selective evolution to develop the smooth working human body in its myriad of details. Disturbances of function caused by the upright attitude give rise to numerous disorders, and it may be that the proper therapeutic approach is to attempt to restore orthostatic anatomic displacements of vital organs.

Many diseases, including arthritis, are believed by some doctors to be related to an imbalance of the interhormonal system, especially of the adrenal gland, since it is possibly the only hormonal gland that is disturbed by the upright body position. If this is true, the logical approach would be the restoration of the gland to its birth position, thus restoring its blood supply and relieving irritation to its delicate nervous mechanism and not by administration of synthetic hormones, especially when we cannot be too sure of accuracy in obtaining the sequential factors of hormones from nature. Presumed authorities in rheumatoid arthritis maintain that the damage in these joints is irreversible. This may be the observation of those using so-called substitutive therapy, but it has been our observation in some cases that these joints can be restored to normal or near-normal function. Thus, ACTH and similar products may act to stimulate the function of already depleted adrenal glands, and also act to upset, in some manner, the normal interhomonal balance, Yet their use in reality offers considerable proof of the saneness of our approach in trying to restore adrenal function so that it can act in the normal interbalance of the natural hormonal system. For this comment we thank contemporary research workers, though we suspected it nineteen years ago.

The first "nephropexy" was done by Hahn in 1881. His technic occasioned much

*Presented at the Eightieth Annual Session of the Colorado State Medical Society at Colorado Springs, September 22, 1950. The author showed color moving pictures of five cases taken before operation and from seven days to twenty years after operation, which the author will loan on request to any medical society.

needless trauma both in his approach and his method of renal fixation. It relieved less than 40 per cent of cases and thirty years later was given up and condemned by the very men who had used it. In their prejudice they condemned also any man who even tried to devise a successful method. Even today the mention of the word "nephropexy" offends some doctors, but today the operation appears to be coming back, for the need is still great. Therefore, a safe and sane method of nephropexy should be devised. We have used human fascia lata in varying technics with reasonable success, but in 1911 began using

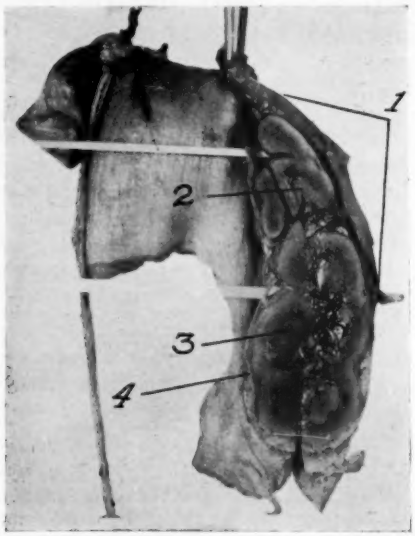

Fig. 1. Newborn babe. Sagittal section through diaphragm, adrenal and kidney and perirenal capsule. 1, Diaphragm; 2, adrenal gland; 3, kidney; 4, perirenal capsule.

Longyears' suggestion of his "nephro-colic ligament" with certain variations, using autogenous fascia with excellent results, and after numerous materials we have found No. 2 forty-day chromicized catgut very satisfactory. In the period from 1911 to 1931, we noticed relief of renal pain and also of numerous accompanying systematic illnesses. Thus, we were soon able to predict for such cases complete and permanent relief from these diseases, but we could not tell ourselves just how it was accomplished. These surprising results included Addison's disease, exopthalmic goiter before or after thyroidectomy, chronic abortions in young women, arthritis, myasthenia gravis and the lesser asthenias, schizophrenia, Reynaud's and Buerger's disease, asthma, juvenile scoliosis, severe anemias, including the pernicious type, chronic stomach troubles, impotence and frigidity.

The apparent true explanation of these unexpected results came in 1931 when Dr. A. D. Catterson, of Denver, suggested "that possibly in our type of nephropexy we were doing something of benefit to the adrenal glands." We found in a study of nearly 100 cases at autopsy, that whatever the renal displacement, that the adrenal gland was pulled from its normal birth position, approximately one-half the distance of the renal displacement. It could be assumed that the blood supply to and from these organs was lessened sufficiently definitely to disturb their function, perhaps also by pulling upon their nerve supply. This is due to the fact that all three of these organs are supported by the same fibrous strands of connective tissue that arise from the inside surfaces of the perirenal fascia, and all portions are lengthened equally and unduly. We then felt that we had a logical and basic explanation of surprising clinical results.

These findings and our method of operation were published in 1933 in both the Journal of Urology, and the Urologic and Cutaneous Review, as well as being presented to the Denver County Medical Society on January 13, 1932; at that time Dr. James. Rae Arneill generously named it "The Fowler Syndrome." In this acquired anatomic anomoly we have either a simple hypoadrenia or perhaps a maladrenia, with embarrassed renal function, often with renal damage plus infection, which may give rise to high blood pressure. All these are usually relieved by the operation. We have rarely seen any evidence of hyperadrenal function.

Biochemists have now identified twenty-eight adrenal steroid hormones of the cortex, and numerous men have expressed the belief of many more, possibly even a hundred. Of these steroid hormones only six have been shown by our biochemists to

have a demonstrable physiological action. Of the other twenty-two they have stated that their function is unknown or else have no function. We feel that a more rational viewpoint would be that after a few hundred million years of selective evolution, it is impossible that we would have twenty-two inactive substances elaborated in the human body, and they must have definite functions; they may even have importance equal to the known six in maintaining normal inter-hormonal balance. We regard the hormonal system as the most important feature of our entire inheritance. Thus the possible explanation of "familial tendencies" may be explained in a family.

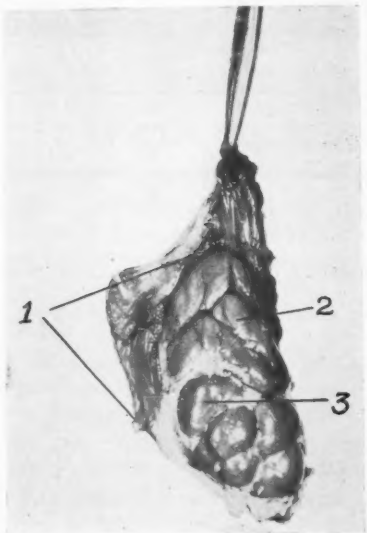

Fig. 2. Newborn babe. Anterior view. 1, Diaphragm; 2, adrenal gland nearly the size of kidney; 3, kidney.

The functions of the adrenal glands are in such delicate balance with the entire hormonal system in "checks and counterchecks," that to date no biochemical research has been able to administer one or more presumed natural or synthesized hormones in effective amounts, or over a sufficiently long period, without producing or inducing hormonal damage or serious interhormonal upset in the interhormonal balance. Today there is no dispute as to the direct relation of numerous obscure diseases to the adrenal cortex. Now it appears evident, in our opinion, that an interhormonal upset in function comes from a definite anatomic anomaly of the kidney and adrenal glands which results in one or more of these obscure diseases. Thus our approach toward the correction of these many diseases is directly at what we believe to be causative factors—to restore normal or near-normal function of the adrenal cortex, rather than by extracts of animal glands. At least seven different solutions have been generally used and, of these, there has been no agreement among biochemists as to which is best. Also it is not known whether all important hormones are included in any of the extracts. Further, the use of these extracts or their synthesis has been called "substitutive" therapy. We feel that a true substitutive therapy would necessarily have to include the proper proportions of all twenty-eight known steroids.

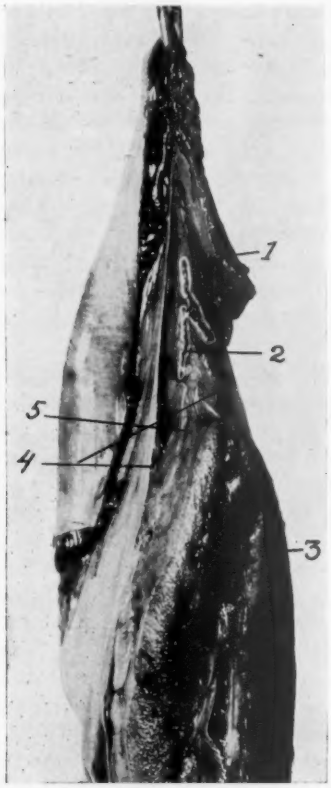

Fig. 3. Aged 23, male. Heavy set and rugged build. Adrenoptosis, 1½ inches. Renoptosis, 3 inches. Adrenal, sclerosed. Kidney, pyonephrotic. 1, Diaphragm; 2, adrenal atrophic and sclerosed; 3, kidney; 4, perirenal capsule; 5, supporting fibers of kidney.

Who is able now or ever to compound them in proper proportion when to date it appears impossible to regulate the dosage of any one of the known six?

Thus, we feel that our approach to the problem is one of sane and safe physiologic surgery, for it is an operation that has no more danger to life from the operation itself than does the accepted risk to life in tonsillectomies or chronic appendices. While it is true that our suggestion entails a major operation with its attending discomforts, it is rare for these sufferers to refuse operation, since it is evident to the layman that it appears to offer a logical chance of permanent relief—and the expense of surgery is really less than any other treatment that requires medication for life.

During the operation, the patient is placed flat on his abdomen, with a pad under each kidney anteriorly. Both sides can be operated easily at one sitting. There is no somatic or renal shock, for the kidneys and adrenal glands are not even uncovered. There is no urinary suppression postoperatively. Postoperative discomforts are similar to those after appendectomy. Our particular incision is at the root of the kidney, affording ready access to the renal pelvis, which is freed in its upper two inches. The operation time for both sides should not be over fifty minutes. The patient may be free of his arthritic pain in three to five days and he has a feeling of well-being; redness and swelling of joints are beginning to be relieved within three to four days. Some ankylosed joints can be moved within five days without pain and may even give a "grinding" noise. After fourteen days in bed without being raised up, patients are gotten up and in three to four days, some of them are able to leave the hospital walking without crutches or cane. While much benefit comes early after operation, benefit will continue even for many months, perhaps even years. In this time many deformities are improved and some are restored to normal. In rheumatoid arthritis there is a process of destruction in joints with deposition of certain minerals, and after operation this process of deposition is reversed and dissolution and absorption takes place, thus showing that what has been called an irreversible condition may become reversible. These patients must follow a physiologic regimen after being home, and should not expose themselves to great physical stress or exposure.

We feel that we have an explanation of the relation of these and other diseases to the adrenal gland, for which many capable men have been hoping and searching during past years, both in etiology and treatment. If we are right, this measure opens up a wide field in physiologic surgery, for there is no acquired mal-anatomy in the human body of such high incidence as general visceroptosis, especially adrenoptosis—and we will probably always walk on two feet!

Case Report

A CASE OF PERIARTERITIS NODOSA TREATED WITH ARTISONE

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It has been known for some time that the administration of ACTH (adreno-corticotropic hormone) or cortisone produces clinical improvement in cases of periarteritis nodosa. Also it has been known that this clinical improvement is transient and that the usual complications result in spite of the administration of these substances. These complications are due to vascular occulsion produced by cicatricial contractions from too rapid healing of the periarterial lesions. Because we wished to avoid this sequence of events we decided to use a mineralocorticoid, namely 21-acetoxy pregnenolone, known under the trade name Artisone (delta 5, pregnene, 3 beta, 21 diol, 20 one-21 monoacetate), Wyeth, Inc. Our purpose in using this drug was twofold: First, we wished to see if the above complications would ensue if another steroid was

* The authors wish to express their appreciation to Dr. Calvin Fisher, Dr. William C. Black, Dr. Irvin Hendryson, Dr. L. E. Daniels, Dr. William A. H. Rettberg and the administration of the St. Luke's Hospital, Denver, for their kind help and advice in the completion of this study.

used, and second, we wished to find out if a lower dosage schedule might avert some of the complications mentioned above. In presenting this case we realize that our controls of the electrolyte balance, fluid balance and other important biochemical determinations have been incomplete.

Subjectively we felt that the patient obtained great benefit from the use of Artisone. However, at no time were we able to find clinical, laboratory, pathological or other evidence that the drug had an effect on the course of the disease. The untoward effects often seen with the use of cortisone or ACTH were not observed.

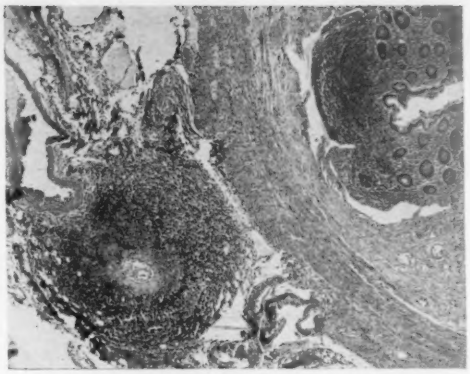


Fig. 1. Vermiform appendix with acute lesion on mesoappendix, X 100.

CASE REPORT

The patient, a 24-year-old white female, first came to the office on August 2, 1949, for prenatal care. At the time she was thought to be nearly four months pregnant and due to deliver about January 4, 1950. History revealed that she had had four previous pregnancies. The first occurred in 1944 and was followed by the delivery of a normal child in the eighth month, the infant dying soon after birth of undetermined causes. It was noted at the time that the delivery was followed by severe episodes of bronchial asthma. Her second pregnancy miscarried at two months without other complications. During her third pregnancy she stated that she suffered from asthma throughout its entire course, and that the asthma continued for approximately four months after delivery. During her fourth pregnancy she was perfectly well until after she delivered a normal boy in the eighth month. Following delivery, however, she suffered severe asthma for almost a year. During the summer of 1949 she was again found to be pregnant and this time had continual attacks of asthma which eventually became so severe that on November 28, 1949, it was necessary for her to be hospitalized. Every conceivable medication was administered without results and on December 15, 1949, she delivered a normal infant. After delivery the asthma temporarily subsided, but in January of 1950 it suddenly recurred and by February was complicated by severe pain in the abdomen which, on February 10, necessitated her hospitalization. At that time her white blood count was reported as being 23,000, 30 per cent of which were eosinophils. There was also indication of a rather marked urinary infection. Because of the fact that her asthma was so severe it was decided to keep her under observation for the present and postpone surgical intervention even though there was strong evidence that she might be suffering from a low grade appendicitis. On February 28, however, the condition of her abdomen became such that it was felt that operation could not be deferred any longer and an appendectomy was performed under spinal anesthesia. On entering the abdomen the appendix appeared to be inflamed and small millet seed nodules were noted covering it and also covering the Fallopian tubes and the parietal peritoneum. The diagnosis of periarteritis nodosa was made by Dr. K. Neubuerger of the University of Colorado School of Medicine on the tissue removed. The patient was discharged from the hospital on March 7, 1950, in fair condition. Following her discharge the patient did not do well and on March 17, 1950, she was admitted to the St. Luke's Hospital.

Physical Examination: The patient was a poorly nourished cachectic white female appearing to be extremely ill. Her skin was cold and clammy, the temperature was 98.6, pulse was 120 and of poor quality, the blood pressure was 144/98 and the respirations were 28. There was a moderately fetid odor to the breath. The scalp appeared clean. The hair was moderately fine and somewhat oily. The pupils were equal and regular although somewhat smaller than usual due to opiates. Reaction to light was present. The extraocular movements were normal. Examination of the fundus was not remarkable; no hemorrhages or exudates were noted. Both tympanic membranes were within normal limits. The teeth were in good repair. The pharynx was somewhat inflamed. The tongue protruded in the midline. There were no glands palpable in the neck and the thyroid was not enlarged. Expansion of the chest was normal. There was a moderate right lateral scoliosis. The breasts were normal and there were no glands palpable in either axilla. The lungs were clear and resonant throughout. Both diaphragms moved freely. The heart was not enlarged to percussion and no murmurs could be heard. The rhythm was regular. The abdomen was moderately distended and there was a diffuse marked tenderness particularly in the right lower quadrant. A rather doughy consistency was noted. Peristalsis was active. There was a midline scar with a small scabbed area in the mid-portion of the scar. A one-plus edema involved both the hands and the feet. The reflexes were physiologic. A moderate pigmentation was noted over the left lateral portion of the thorax. Pelvic and rectal examinations were deferred because of the patient's condition.

Laboratory Examination: During her course in the hospital the number of completed laboratory examinations left much to be desired. In summary, however, it may be said that there could be no correlation established between the drug* and either the urinary findings, the blood chem-

* Averaged 100 mg. daily for three months, 100 mg. every day final month.

istry, the blood counts or the sedimentation rates. The eosinophil counts in percentage reached their peak at 66 per cent about a quarter of the way through her hospital stay and about one-third of the way through her treatment with Artisone. No explanation could be found for this. A sternal marrow biopsy taken midway through Artisone therapy was reported as follows: "Examination of the sternal marrow shows hyperplasia of the granulocytic elements with marked eosinophilic hyperplasia. Megakaryocytes normal. Erythroid series normal." A Kepler-Power test completed at about one-half way through the Artisone therapy was not conclusive. Biopsies repeated on three occasions during her hospital stay did not show definite evidence of healing.

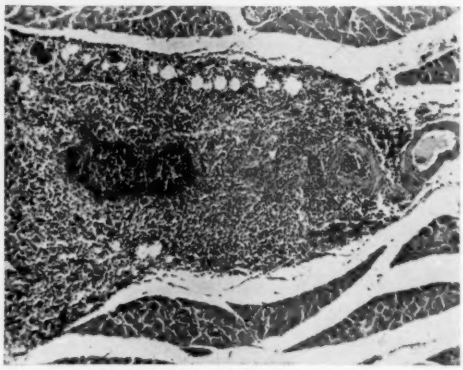
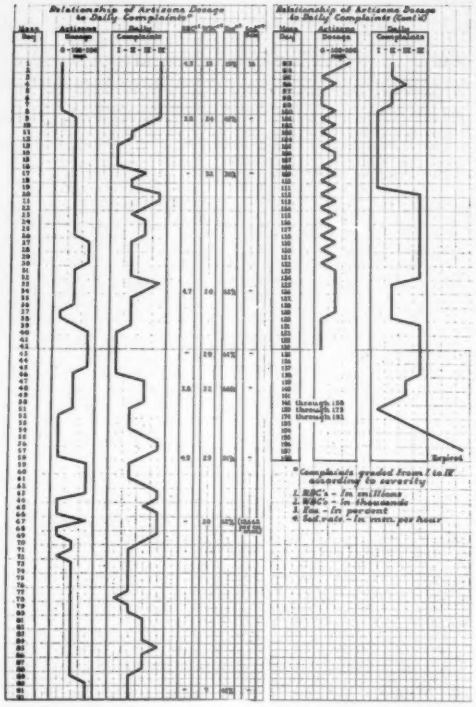


Fig. 2. Muscle biopsy. Acute panarteritis, X 100.



The original electrocardiogram taken on March 6, 1950, showed signs of definite coronary insufficiency, as evidenced by low voltage of T in 2 and 3 and inversion of T in V_1, V_2 and V_3. From then on during the entire course of her illness the other eight electrocardiograms varied slightly with transient and short-lived periods of what appeared to be coronary insufficiency. At no time did the classical electrocardiograph signs of acute pericarditis appear, nor at any time was there any definite shift in the axis or evidence of ventricular strain. These electrocardiograph findings are rather puzzling in the light of the autopsy findings.

Course in Hospital: For reasons already stated the administration of Artisone was begun on the ninth hospital day. Daily observation of the patient's complaints and physical findings were made and graded from I to IV according to the severity of symptoms. The results of these observations will be seen graphed on the accompanying chart.

Examination of the heart elicted a friction rub on the sixty-sixth hospital day. This was observed to be present for the next thirty days and then to disappear. It was also noted by the roentgenologist that the heart was becoming smaller in size during this period. It was felt by all observers that there was a definite constrictive process in progress. This conclusion was borne out at autopsy.

Postmortem Examination on M.M., St. Luke's Hospital, October 4, 1950:

Anatomical Diagnosis:

1. Healed periarteritis nodosa; with residua of lesions in the myocardium, lungs, gastrointestinal tract, lymph nodes, psoas muscle, and bone marrow.

Adhesive pericarditis.

2. Focal pneumonitis, alveolar hemorrhage, congestion and edema, patchy atelectasis and emphysema of the lungs.

3. Hyaline thickening of the basement membrane of bronchioles.

4. Serous atrophy of fat.

Gross Examination:

Externally the body is that of a well developed, and poorly nourished, white female of 26 years of age.

Internally there is almost no fat in the anterior trunk wall. No fluid is encountered in any of the serous sacs. On first inspection the abdominal viscera are apparently of normal shape, configuration, and relationship.

The heart occupies almost a mid-line position and is apparently greatly reduced in size. The parietal pericardium is thickened, fibrous and white. It is densely and rigidly adherent to all areas of the visceral pericardium. The heart is removed from the pericardial sac with the aid of dissection and tearing of these tough adhesions. There is no residual fluid in the pericardial sac.

Dissection of the heart reveals that the valves and chambers are well developed and show no gross evidence of disease. The left ventricle has a wall which averages 1.5 cm. in thickness; this, however, is thought to be hypertrophic. The coronary vessels arise normally and careful dissection reveals no evidence of thrombosis

or inflammatory reaction in the adventitia or other layers of the vessel walls. The great vessels arise normally.

Both lungs are predominantly over-expanded and slightly doughy, but they do have a moderate amount of crepitation. The left upper lobe contains a 5x6 cm. diffuse area near the apex which is extremely dark in color and on cut surface a large amount of blood and edema fluid gushes forth. There is a moderate amount of edema fluid found in all areas of the lung and the posterior-inferior lung segments have a slatey-blue atelectatic appearance.

The pancreas has its soft, yellow, lobulated appearance and the spleen has a mottled pink to fuchsia color, both on cut and uncut surface. The turgor is increased, but evident infractions are found.

The gastrointestinal tract and its mesentery show no grossly abnormal findings. There are a few nodules in the mesentery, but these are evidently normal lymph nodes.

There is extensive serous atrophy of the fat of the greater omentum.

The liver, kidneys, adrenals and reproductive organs reveal no unusual features.

The pituitary gland, brain and meninges all appear grossly normal.

Microscopic Notes:

Heart—The parietal and visceral layers of the pericardium are fused in many areas and there is an edematous, very vascular, loose connective tissue coat, which attains marked thickness. It contains numerous new capillaries and is pervaded by a finely granular albuminoid precipitate. In some areas a few extravascular leukocytes are sprinkled throughout the tissue. These consist of mixed polynuclear and mononuclear cells. A few eosinophils are seen and a few plasma cells, but these two cell types are not unusually prominent. The myocardial fibers are generally of normal caliber and there is a diffuse interstitial edema. The vessels within the myocardium are not unusual except for one small artery and a vein which is surrounded by a group of fragmented eosinophilic fibers, probably collagenous. The transverse sections of the myocardial fibers show some areas that have slight hydropic degeneration.

Lungs—All areas are characterized by a diffuse and severe congestion and edema. A few areas show slight atelectasis but many more are emphysematous. Sections from some regions show a diffuse, intense, alveolar hemorrhage and edema which almost obliterates alveolar walls. In these regions there are small areas of apparent necrosis and a diffuse spread of bacterial colonies. These latter show a very heavy proliferation without any regard for architectural boundaries. In such areas several large engorged veins show an infiltration of these bacteria into their walls along with cellular debris and polynuclear and mononuclear leukocytes. Large parts of the alveoli and interstitial tissues in these regions are infiltrated with the same leukocytes. A bronchus in this area shows a very prominent hyaline, thick, deeply eosinophilic basement membrane in its mucosa; in the submucosa there is a diffuse hyaline fibrosis with a prominent, rather heavy, infiltration of eosinophils and plasma cells. In a nearby bronchiole the same type of basement membrane is noted and in the lumen of this bronchiole one sees heavy palisaded sheets and cords of a similar hyaline material plus cellular debris, leukocytes and red blood cells. However, in the lumen

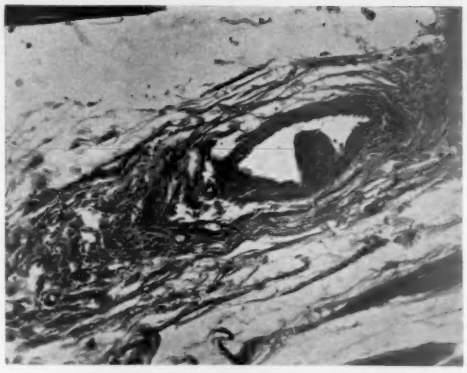


Fig. 3. Skeletal muscle (autopsy). Artery with very mild residual inflammation, X 120.

and in the submucosa eosinophils and plasma cells are rarely, if ever, seen. Throughout the lung parenchyma, other than in the submucosa of the bronchus, there are scattered eosinophils and plasma cells. In several of the interlobular septae there are similarly many neutrophilic polynuclears and edema fluid; these are also seen in a few bronchioles. An acute necrotizing arteritis of the walls of medium sized arteries is present, but appears only in zones of acute inflammation.

Liver, Pancreas and Kidneys—Essentially normal structure.

Spleen—The red pulp is moderately congested and contains a definitely increased number of polynuclear leukocytes. The vessels are not remarkable.

Uterus—The glands are somewhat disorganized but are generally tortuous and lined by a slightly eosinophilic epithelium. The vessels throughout the myometrium show no remarkable features.

Gastrointestinal Tract—Sections of stomach and jejunum show a slight interstitial edema of the muscle layers and the mesentery and the vessels generally show no unusual features. A few small vessels show perivascular fibrosis with small brown pigment deposits in monocytes in the areas.

Lymph Nodes—Examination of three lymph nodes with a medium sized artery in one piece

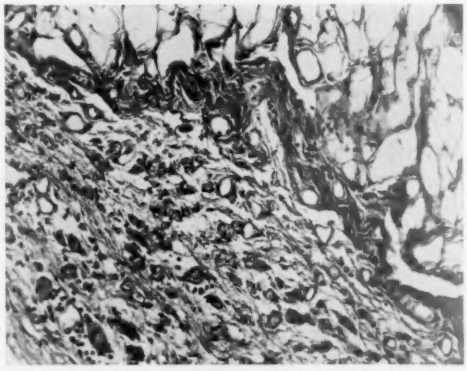


Fig. 4. Pericardium showing fusion of layers, X 120.

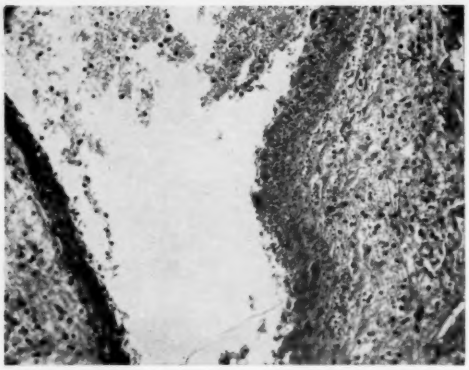


Fig. 5. Lung. Acute vascular lesion, X 140.

of fibrous and adipose connective tissue shows a preservation of architecture of the nodes with a slight edema and congestion of the pulp. One sees a few polynuclear cells throughout the medulla especially and these are almost exclusively eosinophilic.

Psoas Muscle—Examination of the sections shows slight interstitial edema and structurally normal skeletal muscle fibers. Many blood vessels appear normal. Some small arteries have eccentric mural thickenings of hyalin material containing groups of fusioform nuclei. A few monocytes containing brown pigment lie in the perivascular connective tissue.

Brain—Examination of sections from representative areas show a fairly pronounced widening of perivascular lymph spaces. The vessels are generally engorged, but their walls are not unusual. The ground substance shows no alteration of structure or evidence of inflammation.

Bone Marrow—Examination of sections from the vertebral bodies shows a diffuse, fairly marked increase in eosinophils. Most of these are metamyelocytes and non-filamented forms. A number of myelocytes are also seen. Megakaryocytes occur in normal number. Erythropoietic elements are also seen, apparently normal in amount. Plasma cells and their precursors are apparently not increased in number.

Discussion

From the data presented we would be justified in drawing the following conclusions: That we can find no definite correlation between the dosage frequency of Artisone, duration of administration, and the patient's symptoms. Nor did it seem that the Artisone had any effect on the course of the disease since the patient developed severe constrictive pericarditis while receiving the drug. Again we can conclude that this drug does not result in the same types of complications usually described with the use of cortisone or ACTH. No change in the patient's features were noted. There was no acne and there did not seem to be any tendency toward salt or water retention nor an excessive loss of potassium. However, at one time it was thought that there was some mental confusion developing, but this was attributed to the marked pain which the patient suffered almost constantly.

No explanation can be offered for the sudden recurrence of her asthma a week before she died. It was felt, however, that because of the marked constrictive process surrounding the heart that when her asthma did return her cardiac musculature could not overcome the increased strain.

Summary

1. A case of periarteritis nodosa treated with Artisone is presented.

2. There was no evidence that the drug had any effect on the course of the disease or in averting any of its complications.

3. The usual effects noted during the use of cortisone or ACTH were not noted.

Colorado Medical School Honors Dr. Florence Sabin

Dr. Florence R. Sabin, Denver, widely credited with being America's greatest living woman scientist, was honored at recent ceremonies in which the new $1,000,000 cancer wing at the University of Colorado Medical Center was dedicated in her name.

The new wing will be known as the Florence R. Sabin Building for Research in Ceccular Biology. The building is the largest devoted to cancer research in the Rocky Mountain West. Speakers at the dedicatory ceremonies included Colorado medical and political leaders and Dr. Leonard A. Scheele, Surgeon General of the U. S. Public Health Service.

The ceremonies were held December 1 and 2, only a few days after Dr. Sabin celebrated her eightieth birthday. On her birthday proper, colleagues honored her at a special dinner and presented her with a bound volume of felicitations assembled from all parts of the country.

Dr. Sabin has enjoyed a brilliant career as a teacher, research worker, physician, counselor and public health leader. She was recently awarded the General Rose Memorial Hospital's 1951 medal for distinguished public service. She holds honorary degrees from a number of leading universities, and is one of six Honorary Members of the Colorado State Medical Society.

Organization

National Affairs - Proceedings - Programs - Society Notices - News - Auxiliary

ABSTRACT OF MINUTES*

HOUSE OF DELEGATES OF THE COLORADO STATE MEDICAL SOCIETY

81st Annual Session, September 18, 19, 20 and 21, 1951, Colorado Room

Shirley-Savoy Hotel, Denver

FIRST MEETING—Tuesday, September 18, 1951

Dr. W. Wiley Jones, Speaker of the House of Delegates, called the House to order at 10:00 a.m. and recognized Dr. George R. Buck, Chairman of the Committee on Credentials, to report for that committee. Doctor Buck presented the report as printed on pages 3 and 4 of the Handbook with supplementary corrections recommending the seating of Drs. Paul A. Draper and Frank I. Nicks as alternates for Drs. V. L. Bolton and E. F. Geever, both of El Paso County, recommending the seating of Dr. Carl W. Maynard as alternate for Dr. O. C. Dail, Pueblo County, and recommending the seating of Dr. A. B. Gjellum as alternate for Dr. Sidney Anderson of the San Luis Valley Society. Mr. Harvey T. Sethman, Executive Secretary, called the roll from the report of the Committee on Credentials and announced the total number of delegates accredited by the committee answering the original roll call as sixty, more than a quorum. On motion of Dr. Buck the report of the Credentials Committee as amended by him verbally was then adopted.

On motion of Dr. Edgar Durbin the minutes of the 80th Annual Session as published in the December, 1950, issue of the Rocky Mountain Medical Journal in abstract form, supplemented with corrected 1950 Handbooks in the hands of officers of each Component Society, were approved as published, without reading.

Dr. Frank Wilson, Deputy Director of the Washington office of the American Medical Association, was introduced and extended greetings to the House of Delegates.

Speaker Jones presented the list of reference committees he had appointed for this session as published on pages 4 and 5 of the Handbook and announced that although two or three members of those committees had not yet appeared filling of the vacancies would be postponed.

Dr. Samuel P. Newman, Vice President of the Society and Chairman of the Board of Trustees, presented the annual reports of the Board of Trustees as published on pages 5 to 10, inclusive, of the Handbook, and presented three mimeographed supplemental reports including the Annual Audit of the Society's finances made by the firm of Collins, Peabody and Masters, Certified Public Accountants, and a report on the financial status of the Colorado Medical Foundation at the close of the fiscal year, August 31, 1951. One of the supplemental reports recommended a group of clarifying amendments to the By-Laws, as follows:

By-Law Amendments

"In order to conform to a recent amendment of the A.M.A. By-Laws concerning transfers of membership between different County and State Societies, a corresponding amendment to our State By-Laws should be considered. Up to now our By-Laws have provided that when a member transfers he can retain membership in his original society for one year pending action on his application to the society having jurisdiction over his new residence. The A.M.A. has reduced this period to six months. The following amendment to our own By-Laws is therefore suggested:

"Amend Chapter XI, Section 9 as it appears on page 30 of the 1950 printed edition of the Constitution and By-Laws by striking out the words 'one year' in the fourteenth line of said section, and substituting therefor the words 'six months;' and further by striking out the word 'year' from the twentieth line of said section and substituting therefor the words 'six months.'"

Second Proposed Amendment

"Two sections of the current State Society By-Laws are concerned with annual reports whereby County Societies are required to certify their officers, delegates, Board of Censors, etc. Currently these sections fix definite dates in each calendar year when these reports must be submitted, when they are delinquent, etc. As a result of adoption of one of the recommendations of the Rich Report four years ago, about one-third of the component societies now elect and install their officers in the fall of each year instead of in January. Two others elect officers in the late spring and install them in September immediately following the summer vacation. Inflexible dates for annual County Society reports therefore have no value to the State Society, and impose definite administrative hardship on some of the component societies.

"Originally the fixed dates for such reports gave the State Secretary annual assurance that all component society officers and delegates were eligible to office and had paid their dues. The long-established dues receipt system removed much of the reason for a fixed date for annual reports. The recent change of election dates by about one-half of the County Societies has removed any remaining reason. Your Board of Trustees believes the By-Laws should still contain some penalty for failure on the part of a component society to report its elections promptly, but this can be done by condensing the By-Law sections referred to. The following amendments are therefore suggested:

"Amend Chapter XI, Sections 11 and 12 as they appear on page 31 of the 1950 printed edition of the Constitution and By-Laws by striking out both of the sections and rewriting as follows:

"Section 11. Within thirty days after any election meeting held by a component society, the Secretary of that component society shall forward to the Executive Secretary on blanks provided by this Society for that purpose, a report certifying the names of the officers, delegates and alternates, censors, and any committees or representatives of that component society required under the authority of this Society. The Executive Secretary shall submit the said report to the Committee on Credentials, and when the report has been approved by that committee, the component society shall be held to be in good standing and its delegates and alternates shall be held to be accredited

*Condensed from the transcript of H. E. Dennis, Certified Court Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates in advance of the Annual Session in the printed "House of Delegates Handbook" or were distributed to members of the House in mimeographed form at the opening of the meeting. Copies of all such reports, corrected to indicate any amendments or rejections by action of the House, are on file with the Secretary of each Component Society and are there available for study by any member of the Society.

for the period covered by the report. No such report may be approved if any members named therein are not at the time in good standing in this Society.

"Section 12. The Committee on Credentials shall immediately notify in writing the last reported officers of any component society whose report required by Section 11 of this chapter is delinquent or is disapproved. If such a report is not made satisfactory to the Committee on Credentials within such time as the committee may fix in such notice, which shall not be less than thirty days after the date of the notice, the component society thus delinquent shall have no representation in the House of Delegates at the next Annual or Special Session of the House, and unless excused by the House at such Annual or Special Session, said component society shall stand suspended. Members in good standing of such suspended society may independently pay to the Executive Secretary their annual assessments to this Society, and if approved by the Committee on Credentials they shall be continued as members of this Society in good standing, pending reorganization or reinstatement of their component society, provided that this privilege to members of a suspended society shall not be extended beyond one year from the date of the suspension."

Speaker Jones referred all of the reports of the Board of Trustees to the Reference Committee on Board of Trustees and Executive Office except the proposed By-Law amendments quoted above which he referred to the Reference Committee on Constitution and By-Laws.

Speaker Jones then called upon Dr. Newman to report the annual nominations of the Board of Trustees for Certificates of Service. Dr. Newman read the following four nominations:

Nomination

Under the Standing Rules of our Society, your Board of Trustees may nominate to the House of Delegates annually one or more names of members other than the President whose outstanding contribution to the purposes of this Society entitles him or them to special recognition through issuance of the Society's Certificate of Service.

Your Board nominates Kenneth C. Sawyer, M.D., of Denver, for this award for 1951.

Dr. Kenneth C. Sawyer is a distinguished alumnus of the University of Colorado whose loyal devotion to that institution is well known. On more than one occasion he has most liberally exercised his abilities to strengthen financial support of the university and especially its School of Medicine.

Last year, acting as a private citizen who felt the welfare of our citizens was endangered by some who would destroy the American way of life, Doctor Sawyer gave unselfishly of his energies in the arena of political action.

His inspirational leadership gave to a cause for which he labored incessantly a note of challenge which inspired men and women in all walks of life in Colorado to accept the responsibilities of citizenship. His efforts, your Board believes, did more than any one thing to implement the credo that "doctors are citizens, too." And because of his contribution, doctors and their wives and thousands of laymen have a better realization of the need for eternal vigilance to protect our freedoms.

Nomination

Under the rules previously referred to, your Board of Trustees is authorized to nominate to the House of Delegates one or more names of persons outside the membership of this Society whose outstanding contribution to the purposes of the Society during the year then closing entitle him or them to special recognition through the Society's Certificate of Service.

Your Board nominates Mr. Garrett W. Craig of Brighton for this award for 1951.

Mr. Craig was state chairman of the Colorado Division of the American Cancer Society during the last year.

It is the opinion of your Board that Mr. Craig endowed the position with qualities of leadership and effective guidance rarely encountered in the activities of voluntary health organizations. His zealous devotion to the fight against cancer was a public service of the highest order to the people of Colorado.

The Colorado Division of the American Cancer Society has the two-fold task of conducting a continuing education program, the value of which physicians are well aware, and of raising the necessary funds to sustain the program. Your Board feels that Mr. Craig's service to humanity as exemplified by his untiring efforts in behalf of the activities of the Cancer Society constitute a noteworthy contribution in the crusade against disease.

Nomination

Under the rules previously referred to, your Board of Trustees nominates Dr. Douglas W. Macomber of Denver for a special Certificate of Service this year to commemorate his twenty years of devoted service as Scientific Editor of the Rocky Mountain Medical Journal.

Dr. Macomber assumed the scientific editorship of our Journal, then known as "Colorado Medicine" and representing only Colorado and Wyoming, in April, 1931. He was then a very young physician, but from the first his editorial abilities and his devotion were beyond question. He and our Journal have grown together. He and his Editorial Board now represent the scientific thinking of five great states, and the Rocky Mountain Medical Journal stands high among medical publications of this country.

Your Trustees believe Dr. Macomber has earned special recognition from the Colorado State Medical Society, as he has earned, and as he holds, the respect and affection of the nation's medical editors and all physicians in the Rocky Mountain region.

Nomination

Under the rules previously referred to, your Board of Trustees may nominate to the House of Delegates the names of persons whose contribution to furthering the aims and objectives of the Society merit issuance of one or more special Certificates of Merit.

For such a special award your Board wishes to nominate Mr. J. Peter Nordlund, attorney-at-law and your Society's legal counsel.

It is the belief of your Board that Mr. Nordlund has provided distinguished service to this Society and the people of Colorado through his ability and energy in the field of medical legislation.

His loyal devotion to public health and the purposes of this Society was a strong factor in the enactment of the now familiar revision of Colorado's health laws a few years ago, and more recently he has been a tower of strength in special legal aid to our Colorado State Board of Medical Examiners.

On motions regularly seconded and carried unanimously in each case, all four of the nominations above quoted were confirmed by vote of the House.

The Reports of the Board of Councilors and the Board of Supervisors as published in the Handbook were presented and referred without discussion to the Reference Committee on Professional Relations.

Report of the President

Dr. Ervin A. Hinds, President, presented the following verbal report:

One of the privileges of the outgoing President is to make a final report to the House of Delegates concerning his year in office and to suggest any recommendations which he thinks might be worth consideration of the House.

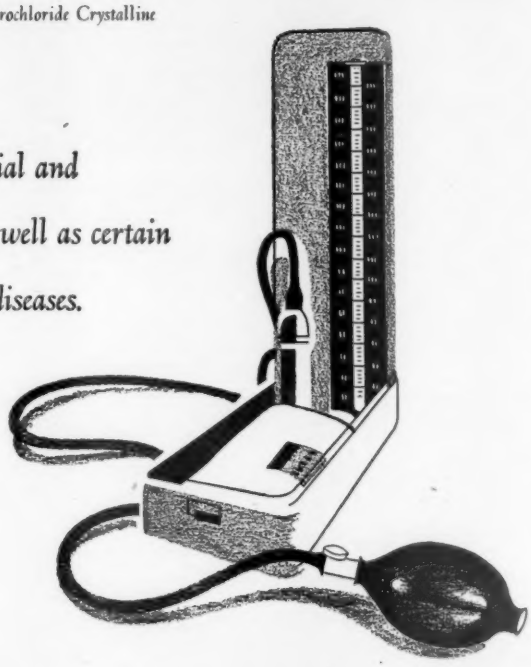
First and foremost I want to put into the record my very sincere thanks and appreciation to all of you and to many other doctors who are not members of the House of Delegates. I thank you for the honor and privilege of serving as your President. I thank you all, and especially all of the other officers and committee chairmen and committee members for the wonderful support you have given me during this year. By working together you have made this a mighty good year for our Society, and I will be able to look back upon my own Presidency of this Society with much pride in our accomplishments.

Also I might say that while we have had a good year, reasonably free of any internal controversy, and freer than most recent years have been of controversy outside the profession—it has been a mighty busy one for all of your officers and for many of you. These last twelve months have of course included a national general election. They have included a regular biennial meeting of the Colorado Legislature. And they have included more large medical meetings of state or regional or national scope than are usually held within our state. These last twelve months have included many other small meetings, meetings of boards and committees, meetings of informal groups large and small. Many of these small meetings some of you are just learning about today in the reports that are in the Handbook. All of these have been worthwhile and have done a great deal toward advancing the progress of our Society.

AUREOMYCIN

Hydrochloride Crystalline

Effective against many bacterial and rickettsial infections, as well as certain protozoal and large viral diseases.



The Geriatrist looks always for a treatment which shall act effectively to curb infection, without unduly upsetting normal metabolic processes and immunologic responses. Aureomycin provides a maximum anti-infectious effect with a minimum of disturbance. Infection in the elderly is more apt to be subacute, or chronic, than acute; and of mixed rather than pure type. Under such conditions, the oral effectiveness and broad activity of aureomycin make it of exceptional value.

Capsules: 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

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I cannot close this year without reminding you of a fact which I am sure is well known to many of you. Namely, that our Colorado Medical Society amounts to only 1 per cent—one-hundredth part—of the membership of the entire American Medical Association. Yet, our little Society with 1 per cent of the membership, has been spoken of scores of times in all parts of the United States as one of the Big Three—one of the three leading state medical societies in the United States. While we can all be proud of this fact, we must all realize that it places upon us the responsibilities of leadership. We must continue to be big enough to justify that mythical leadership which reputation has put upon us.

Actually I have but few recommendations to offer to you other than the general recommendation to which I have just hinted. More specifically, I hope that this House of Delegates and the officers in years to come will continue to refine and expand this wonderful program which our predecessors of a few years ago first put on paper, and which we have been developing.

In more particular fields, I want to urge you to continue the public relations program which has now had four years of proof as to its worth. I hope you will expand that program and develop it even further as the natural limitations of time and energy and human ability and our Society's own budget possibilities will permit.

I suggest that a most important part of our organization solidarity comes from the periodical and continued visits of State Society officers with component societies and with small groups of physicians in all parts of Colorado. I hope that this can be continued but I suggest that you place no more responsibilities for official visitation on your President-elect and President, because whoever holds the Presidential office is already giving as much time to this type of travel as should be expected of him. What I do hope is that other State Society officers can do more visiting with County Societies and perhaps relieve future Presidents of some of it.

I know that some official reports will come before you regarding more representation by this Society officially on the governing bodies of the Blue Cross and Blue Shield organizations. I have not seen the reports and do not know just how they are worded, but I urge you to find some means whereby the medical profession as officially represented by our Society can take a more active part in the direction of those two great and worthy enterprises.

I recommend that the State Society and every component society use this next year or two or three to put the greatest emphasis that has ever been placed upon cleaning up the pollution of our Colorado streams and all our public water supplies. Committees of our Society have worked hard on this matter for several years and have accomplished all that those committees could accomplish. What they have lacked, and what I would urge that you develop for them, is the solid support of all our county and district medical societies, every individual doctor, and by all means the many other powerful civic organizations in every community. In this same connection, I urge all of our county and district medical societies to devote more thought to real community leadership in matters of county and community public health. The State Society cannot do it all. Its real strength lies at the grass roots, and the State Society can hardly be any stronger than the sum of its components.

Again I thank you for the privilege of serving you. Because of your efforts and those of your committees, it has been a great year for the Society and a great year for the person who had the privilege of being your President these last twelve months.

Dr. Hinds' report was received with applause and was referred to the Reference Committee on Board of Trustees and Executive Office. Speaker Jones asked if President-elect Harry C. Bryan had a formal report to offer.

President-elect Harry Bryan: "I have no report. I should like to remind members of the House of Delegates and Colorado State Medical Society that the administration of any president can only be successful as he is given support by the members. That support to Dr. Hinds has been good. I would like to ask you to give your continued support to me during the incoming administration. I thank you very much."

Speaker Jones asked if any other officer of the Society wished to submit a personal report. Dr. George R. Buck, Constitutional Secretary, spoke as follows:

"Mr. Speaker and Members of the House: As retiring Constitutional Secretary I want to thank you for the privilege of having been able to serve you for the past three years.

"I know of no office in the state organization that is more arduous in character, where you put a man in office for three years who ex-officio is a member of both the Board of Trustees and the Public Policy Committee. That means a minimum of two meetings a month and more than likely four to six meetings a month. It has been a very real pleasure to serve you even though it has been arduous and tiring. I know that this body will elect as my successor a man who will do an even better job than I have done. I thank you."

The annual reports of the delegates to the American Medical Association as previously published in the Journal and the report of the Foundation Advocate as published in the Handbook and supplemented by mimeographed detailed reports previously referred to as a supplement to the report of the Board of Trustees were referred to the appropriate reference committees.

The report of the Executive Office Staff was received and referred to the Reference Committee on Board of Trustees and Executive Office, as published in the Handbook. The report was supplemented by Mr. Sethman who pointed out an error in the Handbook whereby the names of Drs. George R. Buck and John M. Foster were erroneously omitted from the list of members of the Committee on Military Affairs.

Supplement to Public Policy Report

The report of the Committee on Public Policy was presented as published in the Handbook and was supplemented by Dr. Irvin E. Hendryson, Chairman, as follows:

At the final meeting of your Committee on Public Policy, representatives of the Associated Collection Agencies presented a request for methods of improving relations between the agencies involved, the medical profession and the public. In considering this proposal the committee was of the opinion that there was a real need for this type of endeavor and recommended that a subcommittee of the Public Policy Committee be appointed to meet jointly with representatives of the collection agencies; these joint committees to study our problems and make recommendations concerning their improvement.

The following resolution was received from the Board of Trustees of Colorado Medical Service:

Resolution

"Whereas, Colorado Medical Service (The Blue Shield Plan) was conceived by the medical profession as a Service Plan designed to give to the majority of subscribers substantially complete coverage for contract benefits, and

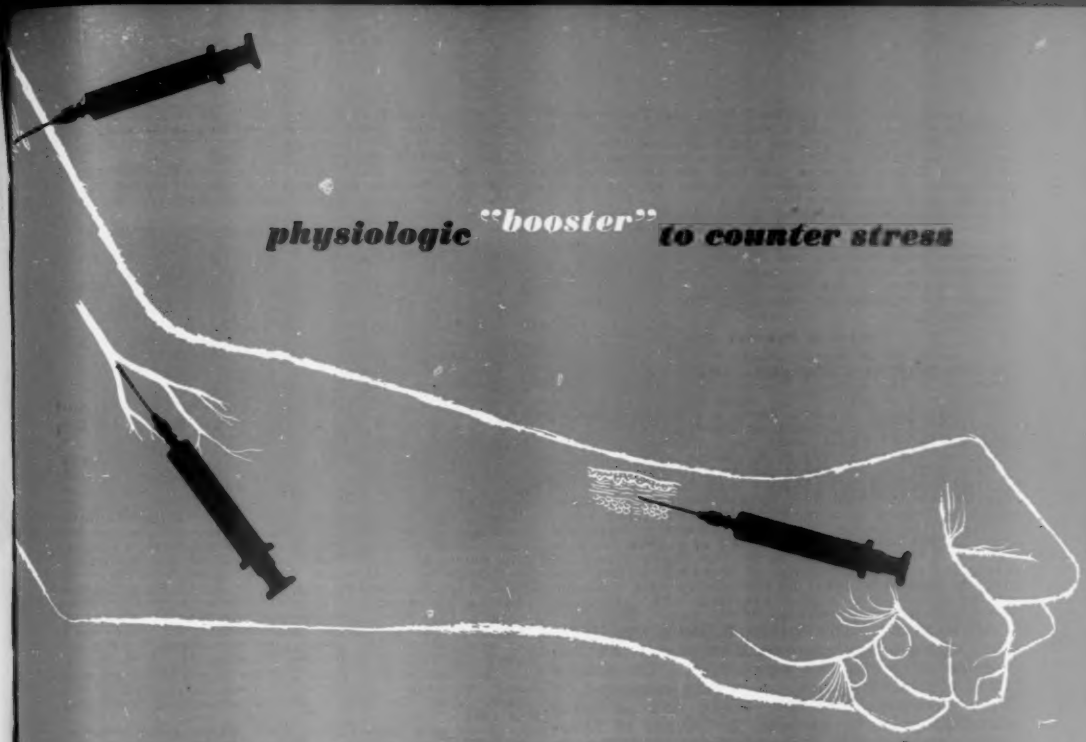
"Whereas, The initial income limit of $2,400 for the family and $1,500 for a single individual per year assured service benefits to a majority of the enrolled residents of Colorado, and

"Whereas, The service benefit feature is the principal advantage of the doctor-sponsored voluntary Blue Shield Plans; therefore, be it

"Resolved: That Colorado Medical Service, Inc., adhere to the objective originally established and in recognition of the change in economic conditions, develop an alternate Blue Shield Plan, with a revised fee schedule and with an annual income limit of $4,500 for the family and $2,600 for the individual which will again provide substantially complete coverage to the majority of the enrolled members electing the new plan; the fee schedule for the new plan to be approved by Medical Service Plans Committee:

"Resolved: That these two Blue Shield Plans shall be the principal medical-surgical programs offered by Colorado Medical Service, Inc., to residents of Colorado."

This resolution was approved and is forwarded to the House of Delegates for action.



physiologic "booster" to counter stress

In situations of bodily stress, endogenous output of adrenal cortical hormones often proves unequal to surging physiologic need. Adrenal cortical function warrants therapeutic support in patients with severe burns or infections as well as in medical and surgical convalescence complicated by adrenal insufficiency. For an exogenous "booster" source to help meet the demands of such stressful states . . .

℞ Upjohn *Adrenal Cortex Extract*

10 cc. and 50 cc. vials of sterile solution for subcutaneous, intramuscular, or intravenous injection.

The potency, purity and standardized metabolic range of this and other products are pioneering contributions to medical practice from Upjohn research in adrenal physiology and in the elaboration of extracts providing *all* the vital adrenal cortical hormones.

Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent of 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol 10%.

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Research *for Medicine . . . Produced with care . . . Designed for health*

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A report was also received from the Tuberculosis Control Committee, and a resolution concerning the use of BCG vaccine. It was the feeling of the Committee on Public Policy, that no action was necessary by this committee and that the resolution be submitted as a supplemental report by the Committee on Tuberculosis Control.

A request was received from the University of Colorado School of Medicine concerning an opinion in permitting osteopathic physicians to attend courses presented by the Postgraduate School of Medicine. A motion was passed that it be left to the discretion of the school authorities as to who should be allowed to enroll in their postgraduate courses.

Medical Practice Act

As indicated in our original report, a survey was made to explore the opinions of the profession in relation to the Medical Practice Act. Excellent response was obtained. The answers all supported the principles of the act. There was some disagreement as to wording and phraseology as well as interpretation. There were very few suggestions that the act be repealed. A summary of the statistics will be available to the Reference Committee and the letters also will be available to the Reference Committee. By motion, the committee went on record as supporting the underlying principles of the Medical Practice Act, and recommends that a joint committee, composed of representatives of the affected groups, meet for the purpose of exploring the possibilities of working within the act; to obtain a legal interpretation and analysis of the act; and to enable hospitals and doctors to work within the provisions of the act.

On motion of Dr. George R. Buck the House then voted to go into executive session for discussion of the above supplement. On arising from executive session, on motion suggested by Vice President Newman, made and seconded simultaneously by several, the House of Delegates extended a unanimous rising vote of thanks to Dr. George R. Buck for the work he had done for the Society this past year. Speaker Jones then referred the several reports of the Public Policy Committee to appropriate reference committees.

Reports of the Committee on Health Education, the Committee on Library and Medical Literature, the Committee on Medical Education and Hospitals, and the Committee on Medical Service Plans, each as published in the Handbook, were received and, there being no discussion, were referred to appropriate reference committees.

Dr. J. R. Blair, Chairman of the Committee on Medical Service Plans, supplemented the published report of that committee as follows:

Since the annual report was published in the Handbook the Medical Service Plans Committee has had another meeting, at which time several matters were brought up at the request of the Board of Trustees, and as a result of that meeting this committee has two resolutions to place before you.

Resolution

"Whereas, The two members of the Colorado State Medical Society on the Board of Trustees of Colorado Hospital Service are, each year, appointed on the basis of designation by the President of the Colorado State Medical Society; and

"Whereas, Said appointees should, as official members of the Colorado State Medical Society, feel a definite responsibility to the Society;

"Therefore, Be It Resolved: That the President of the Colorado State Medical Society be urged to give serious consideration to the selection of the two representatives who should serve a term of at least two and not more than four years and that these appointees be responsible to and communicate with the Public Policy Committee of the Colorado State Medical Society on all consequential matters."

Resolution

"Whereas, Colorado Medical Service is sponsored by the Colorado State Medical Society; and

"Whereas, At least twelve of the nineteen members of the Board of Trustees of the Colorado Medical Service must be members of the Colorado State Medical Society; and

"Whereas, It is at times difficult to elect members to the Board who are willing to give their time to the advancement of our Voluntary Prepaid Medical-Surgical Plan; and

"Whereas, Said M.D. members of Colorado Medical Service should feel a distinct obligation to the Colorado State Medical Society; therefore, be it

"Resolved: That the Board of Trustees of the Colorado Medical Service be memorialized to establish a committee to consist of two members of the Board of Trustees of the Colorado Medical Service; two members appointed by the Board of Trustees of the Colorado State Medical Society; and the Presidents of the Colorado Medical Service and Colorado State Medical Society in ex-officio capacity, which committee shall consider the proper candidates to fill vacancies that may occur on the Board of Trustees of the Colorado Medical Service, Inc."

Dr. George C. Shivers, Treasurer of the Society, discussed the supplemental report of the committee as follows:

"With due apologies to those present who have worked under the old Blue Shield Plan, and recognizing that there are a number of delegates who are not familiar with the surgical phase of Colorado Medical Service, I would like to state briefly for the benefit of those members that under the contract with which we have all been working the surgeons in the State of Colorado are obligated to make no additional charge to any member of the Colorado Medical Service if he be in a family having an income of less than $200 a month. This means that the average surgeon in the State of Colorado is accepting anywhere from one-third to one-half of the fee which he charged as long back as 1932. I am sure I speak for a majority of the doctors in Colorado when I say that we are still working for the same fees, as a whole, we received at the time I started practicing medicine, in 1932.

"Your new Blue Shield Plan, which is to be submitted to the House of Delegates by action of the Public Policy Committee, proposes to increase the fee schedule, and to raise the patient's family exemption to $4,500 a year. In other words, any family which receives $4,500 a year or less cannot be charged anything over and above whatever fee schedule is set by the Colorado Medical Society. I don't know how this affects Denver, but I venture to say that most of the doctors out in the State of Colorado will have at least 80 per cent of their patients fall within this scale. Should the fee schedule set by the Colorado Medical Service be comparable with the fees charged today, I doubt if there would be any objection. I am informed that the ophthalmologists and orthopods, and maybe others, have been canvassed relative to the proper fee schedules. As yet the general surgeon has not been approached in regard to this matter. It is my understanding, and if I am wrong, I stand corrected, that this contract at present is being submitted to the House of Delegates for approval without as yet any fee schedule having been established and approved by the medical profession as a whole.

"It is my understanding that this was to be referred to the committee, probably with power to act.

"This vitally affects the finances of the average doctor of the State of Colorado and I think this is much too big a proposition to be settled by any small committee of the Public Policy Committee or by any small committee of the House of Delegates. I would like to propose to the House of Delegates that the Colorado Medical Service be required to establish the complete fee schedule which they propose to attach to the new contract; that this be in the hands of all participating physicians of the State of Colorado, and that not less than thirty days thereafter, or if necessary delay until next year's meeting of the House of Delegates, the House of Delegates be permitted to examine and pass on this particular new contract with the Blue Shield."

Dr. Irvin E. Hendryson, Chairman of the Public Policy Committee, continued the discussion as follows:

"Lest there be any misconception about the activities of the Public Policy Committee, or any misconception about the Board of Trustees of the Blue Shield Plan, I should like to make a few remarks in addition to what Dr. Shivers has said.

"The proposed $4,500 income plan is not a "down-at-the-shoestring" level of the plan that was originally contemplated. Actually, in reviewing a rough schedule of fees that have been suggested by the Blue Shield, the fees are much higher than is at present the case in the community of Denver, and

I am sure within the state as a whole. There was no endeavor on the part of the Blue Shield Plan to stuff another program down our throats, where we were trying to carry along and help people who were medically indigent. This is to give people coverage at an income level where it will not be necessary in most cases to charge any additional fee.

"You must readily appreciate that in all of the talk across the country within the last three or four years regarding federalization of medicine, one of the big complaints was that Blue Shield Plans weren't adequate because there was always an additional fee tacked on by the doctor. This particular suggestion and plan is to give coverage to your patients so that they will be satisfied and at the same time you will be satisfied. As near as we have been able to tell, there has been no desire on the part of the Blue Shield Service Plan to stuff anything down our throats.

"In considering this proposal we should look at this thing as something that is progressive, something that will do our patients good. When you see some of the copies of the fee schedule that they are working on, I think most of you will be happy. This is not any time to get hysterical about this. I think it is progressive. I think it is good. I think it deserves a lot of calm and cool consideration on your part."

There being no further discussion, Speaker Jones referred the supplemental report of the Committee on Medical Service Plans together with the above discussion to the Reference Committee on Public Relations.

The following reports as published in the Handbook were then received in order, each was opened individually to discussion but there being none in each case the committee report was referred to the appropriate reference committee:

Medicolegal Committee, Subcommittee on Hospital and Professional Relations, Subcommittee on Publicity, Subcommittee on Legislation, Subcommittee on Nurses' Education, Subcommittee for Medical Practice Act, Subcommittee on Special Health Articles, Subcommittee on Weekly Health Stories, Committee on Scientific Work, Committee on Arrangements, General Committee on Public Health, Cancer Control Committee, Committee on Chronic Disease, Committee on Industrial Health, Committee on Maternal and Child Health, Mental Hygiene Committee, Committee on Rehabilitation and Crippled Children, Committee on Rural Health and Health Councils, Committee on Sanitation and Committee on Tuberculosis Control.

Report on BCG Vaccine

Dr. John I. Zarit, Chairman of the Committee on Tuberculosis Control, supplemented that committee's report as follows:

"A special meeting of the Tuberculosis Control Committee was held on August 22, 1951, to discuss the advisability of the use of BCG Vaccine in the State of Colorado. Your committee adopted the following resolution:

Resolution

"Whereas, The use of BCG vaccine is authoritatively reported to provide a relative immunity of varying degree and duration, and

"Whereas, The American Trudeau Society after extensive consideration has said 'BCG vaccine, prepared under ideal conditions and administered to tuberculin negative persons by approved technics can be considered harmless;' be it therefore

"Resolved: That the House of Delegates of the Colorado State Medical Society approve the use of BCG vaccine in the State of Colorado;

"(1) Provided that its use be limited to newborns or those persons with negative tuberculin skin test reaction who may be exposed to unusual hazards of tuberculosis infection greater than the danger experienced by the general population; and

"(2) Provided that the vaccination be performed by physicians designated by the Advisory Committee on BCG Vaccine for the Colorado State Department of Public Health; and

"(3) Provided that the vaccine employed be obtained from the laboratories approved by the United States Public Health Service or the Colorado State Department of Public Health; and

"(4) Provided that all instances of persons vaccinated with BCG vaccine shall be reported to the Colorado State Department of Public Health; and

"(5) Provided that recognition be given to the fact that the use of BCG vaccine is not a substitute for accepted methods of tuberculosis prevention and control, and should not lead to a relaxation of such precautions."

Speaker Jones referred the supplemental report above to the Reference Committee on Public Health. The following additional annual reports were then received, opened to discussion in each case and referred to the appropriate reference committees as published in the Handbook:

Committee on Venereal Disease Control, Advisory Committee to the Woman's Auxiliary, Advisory Committee to U.M.W. Welfare and Retirement Fund, Committee on A.M.A. Educational Campaign, Medical Disaster Commission, Committee on Military Affairs, and Committee on Rocky Mountain Medical Conference.

R.M.M.C.

Mr. Sethman reported that within the last few days he had attended the annual meetings of the Houses of Delegates of both the Utah State Medical Association and the Montana Medical Association, that both those bodies had approved the report of the Rocky Mountain Medical Conference Continuing Committee, had approved continuance of the Conference on a biennial basis, rotating its meetings between Denver, Salt Lake City, and Albuquerque, and had approved, among the several suggestions offered by the committee, the one calling for biennial contributions from each of the five participating states to finance the Conference without registration fee. Mr. Sethman's supplemental report for the Committee on Rocky Mountain Medical Conference was referred to the Reference Committee on Professional Relations.

Reports of the delegates to the Colorado Interprofessional Council and the representative to the Rocky Mountain Radio Council were then received and referred to reference committees without discussion.

Constitutional Amendments

The next order of business was unfinished business remaining from the last annual session. The Executive Secretary reported the only unfinished business on the desk as a group of constitutional amendments proposed one year ago by the then retiring President, Dr. Fred A. Humphrey, concurred in by the Board of Trustees and tentatively approved by the House of Delegates of the 80th Annual Session. These related amendments would create as permanent constitutional offices of the Society the offices of Speaker and Vice Speaker of the House of Delegates. These offices were created on a temporary basis one year ago pending possible final adoption of a constitutional amendment this year to make them permanent. The amendments as proposed were reworded slightly by the Reference Committee of the House of Delegates one year ago and as then amended and approved by the House of Delegates for final adoption at this 81st Annual Session, the final draft of the proposed amendments is as follows:

Amend Article V entitled "House of Delegates" by rewriting the first sentence of Section 2 thereof to read as follows:

"Section 2. The House of Delegates shall be composed of the Speaker and Vice-Speaker of

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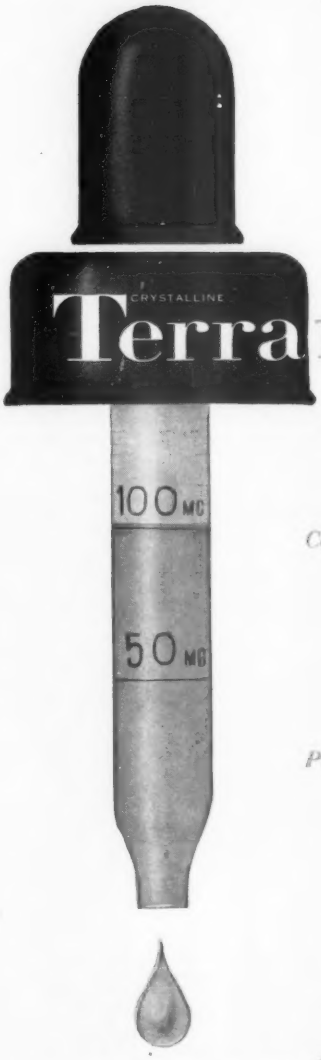

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the House of Delegates, and delegates (or their alternates, in case of delegates' disability) elected by the component societies in proportion to their Active Membership in a manner to be provided for by By-Laws enacted hereunder." (Secretary's note: The remainder of Section 2, reads as follows: "Members of the Board of Trustees, the Councilors, the Delegates to the American Medical Association, and all Past Presidents of the Society shall be, ex-officio, members of the House of Delegates without the right to vote").

Amend Article VII entitled "Officers and Boards" by inserting after the word "Treasurer" in Section 1, the words "a Speaker of the House of Delegates, a Vice-Speaker of the House of Delegates."

Amend Article VII, entitled, 'Officers and Boards" further by inserting after the word "year" in the sixth line of Section 5, the following sentence: "The Speaker and the Vice-Speaker shall be elected for terms of one year each."

Speaker Jones announced the House could now act upon these Constitutional Amendments. On motion of Dr. J. H. Amesse, regularly seconded and adopted without dissent, the House voted to amend the Constitution as proposed above by the preceding House of Delegates. Speaker Jones then declared that more than the required two-thirds of the members of the House of Delegates having voted in the affirmative, the Constitution was now so amended. Speaker Jones then made the following statement:

"By so amending the Constitution you have established your present Speaker and Vice-Speaker of the House as Constitutional Officers of the Society for the balance of this Annual Session, and therefore their individual seats in the House of Delegates are automatically vacated. The Chair would therefore like to entertain a motion that Dr. John B. Grow of Denver be now seated in place of Dr. Wiley Jones, who was seated by action of the Credentials Committee before the adoption of this Constitutional Amendment; and similarly that Dr. F. E. Roark of Morgan County be seated as a delegate in place of Dr. Paul R. Hildebrand, who was previously seated by the Credentials Committee."

On motion of Dr. Frank McGlone, seconded by several, the above suggestion of the Speaker was adopted.

Election of Nominating Committee

Under new business the first order was the election of the Committee on Nominations, to consist of five delegates, no two from the same component society. The following delegates were nominated for positions on the committee:

Dr. Kenneth C. Sawyer, Denver County.
Dr. Lester E. Thompson, Boulder County.
Dr. Eugene B. Ley, Pueblo County.
Dr. J. L. McDonald, El Paso County.
Dr. Thomas K. Mahan, Mesa County.

Speaker Jones called for further nominations, but there being none and there being only five delegates nominated for the five positions on the committee, the Speaker entertained a motion to close the nominations and direct the Secretary to cast the unanimous ballot of the House for those named above. Dr. Harry C. Hughes made the motion which was seconded by several and carried unanimously. (Secretary's note: The Committee on Nominations elected its own Chairman and by later action the same day elected Dr. Thompson as Chairman.)

Nominations for Supervisors

Speaker Jones called attention to the By-Law provision inviting component societies to submit advance nominations for members of the Board of Supervisors. He directed Mr. Sethman to read the appropriate section of the By-Laws and to announce any advance nominations received by his office. The following advance nominations were read and recorded:

The Washington-Yuma County Medical Society nominates Dr. C. J. Bennett.

The Northwestern Colorado Medical Society nominates Dr. Ligon Price.

The Northeast Colorado Medical Society nominates Dr. Portia McKnight Lubchenco.

The Prowers County Medical Society nominates Dr. J. E. Nienhuis.

The San Luis Valley Medical Society nominates Dr. V. V. Anderson.

The San Juan Basin Medical Society nominates Dr. Richard T. Speck.

The Pueblo County Medical Society nominates Dr. George M. Myers.

The Boulder County Medical Society nominates Dr. David W. McCarty.

The above nominations were submitted to the Nominating Committee. There being no additional new business offered in response to the Speaker's request, the Secretary made routine announcements concerning meeting places for reference committes and the Speaker declared the House adjourned until 5:00 p. m., Wednesday, September 19, 1951.

SECOND MEETING—Wednesday, Sept. 19, 1951

Dr. Paul R. Hildebrand, Vice-Speaker, called the House to order. Dr. Buck reported for the Credentials Committee, recommending that Dr. C. T. Frey be seated in place of Dr. L. L. Hick of Delta County who had attended the first meeting but would be unable to attend later meetings of the House. Similarly he recommended that Dr. Frank I. Nicks, alternate for Dr. Geever, be seated for El Paso County, Dr. Geever having attended the first meeting. Executive Secretary Sethman called the roll and announced that there were fifty-four accredited members of the House present, more than a quorum. Vice-Speaker Hildebrand then declared the House organized and on motion of Dr. E. A. Elliff the supplementary report of the Credentials Committee was adopted and the two alternates were seated.

Condensed minutes of the first meeting of the House were read by Mr. Sethman and there being no additions or corrections the Chair declared the minutes approved as read. The Secretary announced on behalf of Speaker Jones that the Speaker had appointed Dr. Harry C. Hughes as temporary chairman of the Reference Committee on Military Affairs in the absence of Chairman Weaver.

Dr. Edward J. McCormick of Toledo, Ohio, a Trustee of the A.M.A., Dr. James McVay of Kansas City, Chairman of the A.M.A. Council on Medical Service, and Dr. Joseph D. McCarthy of Omaha, a member of that Council, were introduced to the House as guest speakers of the annual session.

There were no further annual reports, all having been completed at the previous day's meeting. The Vice-Speaker then called for reports of Reference Committees. The following report was read by Dr. Frank H. Zimmerman, Pueblo, chairman, and was adopted section by section and as a whole without amendment.

Report of Reference Committee on Board of Trustees and Executive Office

(a) Report of the Board of Trustees—Your Reference Committee approves the report of the Board of Trustees as it appears on pages 5 and 6 of the Handbook and in mimeographed supplement form. Your committee recommends that the annual dues

remain at $50.00 and that the present over-all program of the Society be continued with expansion in new directions at the discretion of the Board of Trustees.

(b) Your committee approves the report of National Activities included in the Trustees' report on pages 6, 7, and 8 of the Handbook.

(c) Your committee was particularly impressed by the section of the report dealing with Public Relations as it appears on pages 8 and 9 of the Handbook and wishes to compliment the Trustees on the achievements reflected therein.

(d) In reference to the section headed Denver Medical Building on page 9 of the report, your committee recommends that the Board of Trustees exercise its judgment in accepting the invitation of the Denver County Medical Society regarding utilization of office space in the projected Medical Society building when the building plan has advanced to predictable completion.

(e) Your committee approves the supplemental report of the Board of Trustees as it appears on pages 9 and 10 of the Handbook and in the mimeographed form as distributed at the opening session of the House of Delegates.

Your committee recommends approval of the budget as submitted by the Board of Trustees to be administered at the Board's discretion as provided in the Constitution of the Society.

Your committee commends the retiring administration for its program of "internal education" and recommends that the practice be continued and expanded on a state-wide basis.

Your committee approves the Auditor's opinion and report and wishes to call attention of the membership to the reduction in operating costs which the audit reflects as evidence of good management on the part of your executive body.

(f) Your committee approves the report of the Foundation Advocate as it appears on page 12 of the Handbook and in mimeographed supplement form.

(g) Your Reference Committee approves the report of the Executive Office and wishes to call particular attention to the supplemental report relating the status of membership as reflecting the growth of the Society. The committee wishes to commend the administrative authorities of the Medical Center of the University of Colorado for their efforts to encourage Medical Society membership among the faculty.

(h) Your committee recommends that the House of Delegates express its appreciation to the staff of the Executive Office for their efficiency and loyal service. In particular the committee feels that the part played in the Society's public relations program by Executive Office personnel has been of inestimable value. The committee urgently recommends that these activities be continued.

(i) Your committee approves the report of the Advisory Committee of the Woman's Auxiliary and commends both the committee and the Auxiliary for their excellent work.

(j) Your committee approves the President's report as read before the open session of the House of Delegates and recommends that the traditional visits of the President to component societies be delegated wherever possible to other elected officers of the Society who will accompany the Executive Secretary or his assistant.

(k) It is your committee's recommendation that the retiring President be given official commendation for his admirable administration and his large share in the achievements of the Society. The committee proposes that the House of Delegates express its thanks and appreciation to Dr. Hinds for his services.

F. H. ZIMMERMAN, Pueblo, Chairman;
KENNETH C. SAWYER, Denver;
WILLIAM A. LIGGETT, Denver;
WILLIAM B. CONDON, Denver;
I. E. HENDRYSON, Denver;
N. A. MADLER, Weld;
THOMAS K. MAHAN, Mesa;
J. D. STEWART, Larimer.

Chairman Zimmerman announced to the House his thanks to the members of the Reference Committee for their long and faithful service in working on the reports they had considered. The Vice-Speaker then called upon Dr. R. A. Hoover, Chaffee County, who presented the following report, which was adopted without dissent. Following adoption of the report, on separate motions duly seconded and adopted unanimously in each case, the three proposed amendments were adopted and the Chair declared them so adopted and in force.*

Report of the Reference Committee on Constitution and By-Laws

Your Reference Committee on Constitution and By-Laws recommends the adoption of the proposed amendments submitted to the House immediately before adjournment of the First Meeting thereof.

R. A. HOOVER, Chaffee, Chairman;
M. G. NIMS, Denver;
J. L. McDONALD, El Paso;
L. E. THOMPSON, Boulder.

Dr. J. L. Sadler, Larimer County, chairman, then presented the report of the Reference Committee on Scientific Work as follows, which was thereupon adopted section by section and as a whole, on motions duly seconded in each case, all votes being unanimous.

Report of the Reference Committee on Scientific Work

(a) Your committee moves the adoption of the report of the Committee on Library and Medical Literature as printed on pages 19 and 20 of the Handbook.

(b) Your committee moves the adoption of the report of the Committee on Medical Education and Hospitals as printed on pages 20, 21, and 22 of the Handbook.

It is regretted by your committee that the Korean War has necessitated the marking of time insofar as the extension of the general practice residency of the University of Colorado into the hospitals of smaller communities is concerned.

Your committee would urge the staffs of the hospitals of local communities to become familiar with the requirements to participate in this program as defined by the Committee on Medical Education and Hospitals of the Colorado State Medical Society in the Statement of Minimal Standards.

Your committee recommends that the Colorado State Medical Society support and encourage the extension of the mutual program of the University of Colorado and the Colorado State Medical Society in providing visiting teams of consultants as described in the report of the Committee on Hospitals and Medical Education.

(c) Your committee recommends the adoption of the reports of the Committee on Scientific Work and the Committee on Arrangements as printed on pages 32 and 33 of the Handbook. It should be pointed out that while these two reports are short, they do not truly reflect the staggering amount of work necessary for the realization of the programs of the caliber which has been the privilege of this Society to enjoy.

J. L. SADLER, Larimer, Chairman;
E. PAUL SHERIDAN, Denver;
WARD DARLEY, Denver;
ALVIN E. DAHL, Arapahoe;
J. E. DONNELLY, Las Animas;
SIDNEY ANDERSON, San Luis Valley.

Vice-Speaker Hildebrand next called upon Dr. William C. Service, Chairman of the Reference Committee on Public Relations. Dr. Service presented the following partial report of that Reference Committee which was adopted section by section and as a whole.

First Report of the Reference Committee on Public Relations

(a) This committee recommends that the report of the Committee on Health Education as printed on pages 18 and 19 of the Handbook be approved.

(b) Your committee recommends that the report of the Subcommittee on Hospitals and Professional Relations as printed on page 29 of the Handbook be approved.

(c) Your committee recommends that the report of the Subcommittee on Publicity as printed on page 29 of the Handbook be approved.

(d) Your committee recommends that the report of the Subcommittee on Legislation as printed on page 30 of the Handbook be approved.

(e) Your committee recommends that the report of the Subcommittee for the Medical Practice Act as printed on page 30 of the Handbook be approved.

(f) Your committee recommends that the report of the Subcommittee on Special Health Articles as printed on page 31 of the Handbook be approved.

*See wording of amendments, Pages 958 and 960.

(g) Your committee recommends that the report of the Subcommittee on Weekly Health Stories as printed on page 31 of the Handbook be approved.

(h) Your committee recommends that the report of the Advisory Committee to the United Mine Workers Welfare and Retirement Fund as printed on page 43 of the Handbook be approved.

(i) This committee recommends that the report of the Committee on A.M.A. Educational Campaign as printed on page 44 of the Handbook be approved.

(j) This committee recommends that the report of the representative to the Rocky Mountain Radio Council as printed on page 49 of the Handbook be approved.

(k) As regards the report of the Committee on Medical Service Plans as printed on page 22 of the Handbook, your committee approves paragraphs one, two and three. In view of the fact that the Board of Trustees of the Colorado Medical Service has not at this time submitted a new service benefit contract and fee schedule, paragraph four is not approved.

(l) Since responsibilities of the Committee on Medical Service Plans extend beyond problems associated with Blue Shield, paragraph five is likewise not approved.

Resolution Approved

(m) In regard to the supplemental report of the Committee on Medical Service Plans, which reads as follows:

"Whereas, The two members of the Colorado State Medical Society on the Board of Trustees of Colorado Hospital Service are, each year, appointed on the basis of designation by the President of the Colorado State Medical Society, and,

"Whereas, Said appointees should, as official members of the Colorado State Medical Society, feel a definite responsibility to the Society;

"Therefore Be It Resolved, That the President of the Colorado State Medical Society be urged to give serious consideration to the selection of the two representatives who should serve a term of at least two and not more than four years and that these appointees be responsible to and communicate with the Public Policy Committee of the Colorado State Medical Society on all consequential matters."

This Resolution was adopted by your Reference Committee.

Resolution Approved

(n) In regard to the supplemental report of the Committee on Medical Service Plans, which reads as follows:

"Whereas, Colorado Medical Service is sponsored by the Colorado State Medical Society and,

"Whereas, At least twelve of the nineteen members of the Board of Trustees of the Colorado Medical Service must be members of the Colorado State Medical Society, and,

"Whereas, It is at times difficult to elect members to the Board who are willing to give their time to the advancement of our Voluntary Prepaid Medical-Surgical Plan, and

"Whereas, Said M.D. members of Colorado Medical Service should feel a distinct obligation to the Colorado State Medical Society;

"Therefore Be It Resolved, That the Board of Trustees of the Colorado Medical Service be memorialized to establish a committee to consist of two members of the Board of Trustees of the Colorado Medical Service; two members appointed by the Board of Trustees of the Colorado State Medical Society; and the Presidents of the Colorado Medical Service and Colorado State Medical Society in ex-officio capacity, which committee shall consider the proper candidates to fill vacancies that may occur on the Board of Trustees of the Colorado Medical Service, Inc."

This section was adopted by your Reference Committee.

(o) Apart from the supplemental report, your Reference Committee recommends that a committee be appointed by the Society's Board of Trustees to explore the feasibility and the means of constituting this House of Delegates as the corporate membership of Colorado Medical Service, by whom its Board of Trustees would be elected.

WILLIAM C. SERVICE, El Paso, Chairman;
BRADFORD MURPHEY, Denver;
WILLIAM R. LIPSCOMB, Denver;
CHARLES L. MASON, San Juan;
J. A. SHAND, Otero;
F. D. KUYKENDALL, Weld;
EUGENE B. LEY, Pueblo.

Report of the Reference Committee on Public Health

Dr. E. A. Elliff, chairman of the Reference Committee on Public Health, then presented a verbal report of that committee, recommending the adoption of the annual reports of the General Committee on Public Health, the Committee on Cancer Control, the Committee on Chronic Diseases, the Committee on Industrial Health, the Committee on Maternal and Child Health, the Committee on Mental Hygiene, the Committee on Rehabilitation and Crippled Children, the Committee on Rural Health and Health Councils. In connection with the report of the Committee on Cancer Control the Reference Committee recommended that each component society should conduct a cancer seminar at least once every two years.

The Reference Committee on Public Health, reporting through Chairman Elliff, approved adoption of the annual report of the Committee on Sanitation with a recommendation that an additional special committee composed of others as well as physicians be created to recommend a sanitation program to the next meeting of the State Legislature. Following discussion from the floor by members of the Reference Committee and by Chairman Hendryson of the Public Policy Committee, the Reference Committee withdrew its recommendation in view of the fact, explained in the discussion, that such a committee already exists by appointment of the Governor of Colorado. The annual report of the Committee on Sanitation was then adopted on motion of Dr. F. H. Good, seconded by several and passed without dissent.

Chairman Elliff then recommended the adoption of the annual report of the Committee on Tuberculosis Control as printed in the Handbook but recommended on behalf of his Reference Committee that the supplemental report of the Tuberculosis Committee submitted at the first meeting of the House of Delegates (see page 966) be rejected. This recommendation of the Reference Committee, after Dr. Elliff's motion to adopt it had been seconded, was discussed at length by Chairman Zarit of the Tuberculosis Control Committee and Drs. R. S. Liggett, H. C. Fisher, Atha Thomas, I. E. Hendryson, Ward Darley, President-elect Bryan, Constitutional Secretary Buck, Frank B. McGlone, S. W. Downing, L. E. Thompson, George A. Unfug, and Dr. Elliff. At the conclusion of the discussion, on motion of Dr. Thomas, seconded by several, the supplemental report of the Committee on Tuberculosis Control was re-referred to the Reference Committee on Public Health for further consideration.

Speaking for the Reference Committee, Dr. Elliff then re-recommended the adoption of the published annual report of the Committee on Tuberculosis Control and the reports of the Committee on Venereal Disease Control. These sections of the Reference Committee report were adopted and then on motion duly seconded and passed without dissent the report of the Reference Committee as a whole, as amended by the re-reference referred to above, was adopted without dissent.

Report of the Committee on Nominations

Dr. L. E. Thompson, chairman, presented the following report of the Committee on Nominations:

Your Committee on Nominations respectfully submits the following nominations for offices in our Society:

President-elect for one year: Dr. William A. Liggett, of Denver.

Vice President for one year: Dr. Claude D. Bonham, of Boulder.

Constitutional Secretary for three years: Dr. Irvin E. Hendryson, of Denver.

Trustee for a three-year term: Dr. Robert T. Porter, of Greeley.

Councilor for a three-year term, representing District No. 1: Dr. Paul R. Hildebrand, of Brush.

Councilor for a three-year term, representing District No. 2: Dr. Ella A. Mead, of Greeley.

Councilor for a three-year term, representing District No. 3: Dr. Osgoode S. Philpott, of Denver.

Members of the Board of Supervisors for a two-year term (six to be elected):

Dr. C. J. Bennett, Washington-Yuma Medical Society, Yuma.

Dr. Ligon Price, Northwest Colorado Medical Society, Mount Harris.

Dr. Portia McKnight Lubchenco, Northeast Colorado Medical Society, Sterling.

Dr. John E. Nienhuis, Prowers County Medical Society, Lamar.

Dr. V. V. Anderson, San Luis Valley Medical Society, Del Norte.

Dr. Richard T. Speck, San Juan Basin Medical Society, Cortez.

Dr. George M. Myers, Pueblo County Medical Society, Pueblo.

Dr. David W. McCarthy, Boulder County Medical Society, Longmont.

Dr. Guy C. Cary, Mesa County Medical Society, Grand Junction.

Delegate to the American Medical Association for a two-year term beginning January 1, 1952: Dr. George A. Unfug, of Pueblo.

Alternate Delegate to the American Medical Association, for a two-year term: Dr. Herman C. Graves, of Grand Junction.

Foundation Advocate for one year: Dr. W. W. King, of Denver.

Speaker of the House of Delegates for a one-year term: Dr. Lester L. Ward, of Pueblo.

Vice-Speaker of the House of Delegates for a one-year term: Dr. Kenneth H. Beebe, Sterling.

The Eighty-third Annual Session of the State Medical Society to be held in Denver in 1953 with the recommendation that the Executive Secretary investigate the possibility of holding the Eighty-fourth Session at the Broadmoor Hotel in Colorado Springs in 1954.

Respectfully submitted.
KENNETH SAWYER,
E. B. LAY,
J. L. McDONALD,
T. K. MAHAN,
L. E. THOMPSON, Chairman.

The report of the Committee on Nominations, not being subject to adoption, was received and placed on file.

There was no unfinished business on the desk and the next order was new business. Dr. William H. Halley, Denver, presented the following nomination for Honorary Membership:

Nomination for Honorary Membership

To the Board of Councilors and the House of Delegates, Colorado State Medical Society:

We take great pleasure in nominating to you, for Honorary Membership in the Colorado State Medical Society, Mr. Joseph William Holloway, LLB., of Chicago.

Mr. Holloway was born in Smithfield, Virginia, in 1892. In 1913 he graduated from Randolph-Macon College and received his law degree from the University of Virginia in 1916. He served in the United States Navy during World War I; and later did legal work for the federal government and for the Tennessee State Health Department, before joining the American Medical Association. He has been with the Bureau of Legal Medicine and Legislation of the A.M.A. since 1925, and has been its director since 1942. He has served American Medicine with great distinction for more than twenty-five years.

Thirteen years ago this autumn the Colorado State Medical Society and every right-thinking citizen of Colorado was under attack in a vicious attempt by selfish interests to destroy Colorado's public health and medical licensing laws, through a proposed constitutional amendment at the 1938 general election. The Central Planning Committee charged with the duty of meeting that attack called on Mr. Holloway for help. He spent many weeks with us in Colorado devoting every waking hour toward guiding us legally and educating the medical profession and the medical students of Colorado in practical politics, a field then unknown to us. To describe the ability, the energy, and the devotion he brought to this Medical Society in one of its hours of most dire need would require a volume.

For all these reasons, we are convinced that Mr. Holloway richly deserves Honorary Membership in the Colorado State Medical Society. We who sign this nomination constituted two of the three members of the Central Planning Committee referred to above, as the then President and Public Policy Committee chairman for the Society. Were the third member of that committee still living, we know in our hearts that the name of John W. Amesse, then President-elect of our Society, would also be appended hereto.

LEO W. BORTREE, M.D.,
WILLIAM H. HALLEY, M.D.

Vice-Speaker Hildebrand called upon the Executive Secretary to certify whether the nomination had been approved by the Board of Councilors as required by the By-Laws. Mr. Sethman certified that the Board of Councilors had approved the nomination at its annual meeting the preceding day.

On motion by Dr. Sadler, seconded by Dr. Darley and carried unanimously, Mr. Holloway was elected to honorary membership in the Society.

Dr. George A. Unfug, Pueblo, presented the following nomination.

Nomination for Honorary Membership

To the Board of Councilors of the Colorado State Medical Society:

The By-Laws of our Colorado State Medical Society provide that any member may nominate for Honorary Membership "persons who have made outstanding contribution to the Constitutional Purposes of this Society," and these rules require that your Board pass upon such nominations before they are presented to the House of Delegates.

Within these provisions, it is my great personal pleasure to nominate Andrew S. Brunk, M.D., of Detroit, Michigan, for Honorary Membership in the Colorado State Medical Society.

At a time when the presidents and other leaders of many State Medical Societies were groping for a medium through which to express progressive ideas to the American Medical Association and to inspire our national parent body to greater activity in the fields of Medical Economics, Medical Sociology and Medical Public Relations, it was Dr. Brunk—then President of the Michigan State Medical Society—who conceived, planned and founded the Conference of Presidents and Other Officers of State Medical Associations. At that time I happened to be President of our Colorado State Medical Society, and so was intimately concerned and deeply cognizant of the courage and foresight of this great Michigan leader, who sparked into being an organization which may well be credited with having in the last six years inspired the modernizing of the American Medical Association.

By this alone I believe Dr. Andrew Brunk has earned the undying gratitude of American medicine. He was the first President of the Conference of Presidents, and was its indefatigable leader for the first several years. It continues as a worthwhile organization aiding the American Medical Association by keeping current officers of State Societies in closer touch with national affairs, even though its orginal and primary purpose has now been accomplished, we hope for all time.

But there is still another reason, which few of our younger Colorado members know. Dr. Brunk, a native of Ohio, who obtained his M.D. from Ohio State College in 1909, was for many years a Coloradoan. He practiced with distinction in La Junta from 1911 until 1924, when he moved to Detroit. He rapidly became a leader in Michigan medicine, and was President of the Michigan State Medical Society in 1944-45. Although now retired from a

once-busy surgical practice, he is still active not only in the affairs of the Conference of Presidents, but also as Treasurer of the Michigan State Medical Society and a member of that Society's Council, corresponding to our own Society's Board of Trustees.

GEORGE A. UNFUG, M.D.

At the request of the Vice-Speaker the Executive Secretary certified that the above nomination had also been approved by the Board of Councilors on the previous day. On motion of Dr. Atha Thomas, seconded by Dr. T. K. Mahan and passed unanimously, the House of Delegates then elected Dr. Andrew S. Brunk to Honorary Membership in the Society.

Dr. E. A. Elliff on behalf of the Northeast Colorado Medical Society presented the following resolution:

"Whereas, The Northeast Colorado Medical Association was issued a charter by the Colorado State Medical Society at the eighteenth annual session held in Colorado Springs, June 20, 1888, under the name of The Northeastern Colorado Medical Association; and,

"Whereas, The original charter and all Society records up to 1907 have been lost and cannot be verified by any known record; and,

"Whereas, There is confusion and uncertainty as to the legal name of this Society;

"The members of this Society do hereby make application to the Colorado State Medical Society for the issuing of a new charter, whereby they shall be known as the Northeast Colorado Medical Society.

"Adopted at a regular meeting of the Northeast Colorado Medical Society held in Sterling, Colorado, on the 13th day of September, 1951.

"K. H. BEEBE, M.D., Secretary."

Vice-Speaker Hildebrand referred the resolution to the Committee on Credentials, as required by the By-Laws.

Dr. Edward J. McCormick of Toledo, Ohio, member of the Board of Trustees of the American Medical Association, was called to the rostrum and addressed the House as follows:

Remarks of Dr. McCormick

"I have been seated back there listening to your proceedings. It reminds me of something that happened the other day. The American College of Surgeons was to have its meeting in San Francisco in November and I received a wire asking me to come there as a member of the American Medical Association Committee on Hospital Standardization to represent the American Medical Association. Arthur Allen was to represent the American College of Surgeons, and Tony O'Rourke from the coast was to represent the American Hospital Association. I was told that the American College of Physicians is to be represented and 'this is to be a symposium on hospital standardization as it has been worked out by your committee,' of which I am a member.

So I phoned the American Medical Association headquarters and talked to Bert Howard about the suggested symposium. I did not know exactly what I would be supposed to say under such circumstances. He said, 'Well, I can't tell you. No one here has been able to figure out what the House of Delegates of the American Medical Association did to the Hospital Standardization business at their last meeting.' And when you finished with your BCG vaccine here I did not know whether you had approved it or disapproved it! I guess all meetings of Houses of Delegates are pretty much the same.

"Several years ago I was your guest in Estes Park at your state meeting. I always hate to go back home from Colorado because my wife has a much better memory than I have and she asks me about various individuals here in Colorado who have impressed her. It always makes me mad. She doesn't ask how I am feeling, how I did, how my speeches were. She wants to know how Harvey Sethman is getting along, and Dr. Woodruff, Dr. Sawyer, Bill Halley, and Dr. Unfug, and some of these others. When I go home this time I am going to tell her I did not see any of my friends in Colorado; that I was stashed away most of the time and didn't attend any of the meetings.

"In all seriousness I want to congratulate you. Dr. Unfug has made some reference here today to my good friend, Dr. Andrew Brunk of Detroit. I recall when I first appeared before the House of Delegates of the Colorado State Medical Society. At that time, while it was a great organization, the American Medical Association was very much like the patient with pernicious anemia whose doctor had never heard of liver extract or folic acid. We were a great organization, but a little bit backward in what we were doing. If you recall my talk at that time you will remember I wasn't backward at all in any criticism that I had to offer. I recognize the fact now, as I look back over the changes that have taken place during the last few years, that the House of Delegates of Colorado State Medical Society has been a very powerful influence in the changes that have taken place.

"I have lived through the establishment of the Washington office. I have lived through the broadening of the public relations program. All of those things I had something to do with, but many of the suggestions did not come from me, of course; they came from organizations like the Colorado State Medical Society. You have a great group of thinkers here and men of action in Colorado. There are Bill Halley and George Unfug and Kenneth Sawyer and Harvey Sethman and a dozen others whom I might mention who have been responsible for the changes that have taken place. The American Medical Association has become a positive organization, respected by the citizens of the United States of America as a group of unselfish men who are willing to do whatever is necessary to preserve democracy. A great deal of the spark that was responsible for that change came, of my knowledge, from the Colorado State Medical Society. And I am not here today just passing out flowers and flattery. I am saying what I actually believe. I think you have made a great contribution.

"What I have just said to you is true. You have been a potent force in changing the entire situation in the American Medical Association, and I as a member of the Board of Trustees of that association thank you, and thank God, that you had the intestinal fortitude to do your part to make the American Medical Association and American medicine an organization that can do something to save the country which we all love. I thank you very much!"

There being no further business for the day Vice-Speaker Hildebrand declared the House adjourned until 8:30 a.m. September 20, 1951.

THIRD MEETING—Thursday, Sept. 20, 1951

Speaker Jones called the House to order and asked for any further report of the Credentials Committee. Chairman Buck of that committee requested that as soon as the roll was called a motion be entertained to seat Dr. A. B. Gjellum of the San Luis Valley Society in place of Dr. Sidney Anderson who had had to leave the meeting. Mr. Sethman called the roll and reported fifty-two delegates, more than a quorum, present. Thereafter, the motion suggested

by Dr. Buck was made and carried without dissent.

By unanimous consent of the House the reading of the condensed minutes of the preceding day's meeting was dispensed with. There were no further reports offered by boards, officers, or regular committees. Speaker Jones therefore called for reports of Reference Committees as the next order of business.

Special Report on Charter

Chairman Buck reported for the Committee on Credentials acting in its capacity as a Special Reference Committee of the House of Delegates on matters relating to component society charters, as follows:

Your Committee on Credentials has considered the request of the Northeast Colorado Medical Society for a reissue of its charter.

This request was submitted because no official record can be found of the change of name of that Society from "Northeastern Colorado Medical Association" as chartered June 20, 1888, to "Northeast Colorado Medical Society," although the Society has operated under the latter name for many years.

Your committee recommends that the charter be reissued as requested.

GEORGE R. BUCK, Chairman,
CHARLES G. FREED,
CARL H. GRAF.

On motion regularly seconded and passed without dissent the report was adopted.

Dr. John A. Weaver, Chairman, reported for the Reference Committee on Military and Miscellaneous Business as follows:

Report of Reference Committee on Military and Miscellaneous Business

(a) Your committee has reviewed the report of the Medical Disaster Commission as printed on page 44 of the Handbook. We realize the nature of this Commission's work is organizational, and we feel that the organization is well established for any possible emergency and that excellent work has been done with the present polio emergency. We commend them for their efforts and recommend continuance of this Commission.

(b) Your committee has reviewed the report of the Military Affairs Committee, whose report in an advisory capacity is printed on page 46. We approve the report of the Military Affairs Committee.

JOHN A. WEAVER, Chairman,
J. S. HALEY,
HARRY C. HUGHES,
CHARLES G. FREED,
C. W. VICKERS.

Second Report of the Reference Committee on Public Relations

Dr. William C. Service, Chairman, reported for the Reference Committee on Public Relations as follows:

(a) The report of the Public Policy Committee as set forth on pages 23 to 28 of the Handbook is approved with the exception of the next to the last paragraph on page 24 which has in effect been superseded by the supplemental report of the Public Policy Committee.

(b) This committee has also considered a supplemental report of the Public Policy Committee. The first paragraph of this supplemental report reads as follows:

"At the final meeting of your Committee on Public Policy, representatives of the Associated Collection Agencies presented a request for methods of improving relations between the agencies involved, the medical profession and the public. In considering this proposal the committee was of the opinion that there was a real need for this type of endeavor and recommended that a subcommittee of the Public Policy Committee be appointed to meet jointly with representatives of the Collection Agencies; these joint committees to study our problems and make recommendations concerning their improvement."

Your committee approves this paragraph of the supplemental report.

(c) The second paragraph of the Supplemental Report of the Public Policy Committee reads as follows:

"The following resolution was received from the Board of Trustees of Colorado Medical Service:

"'Whereas, Colorado Medical Service (the Blue Shield Plan) was conceived by the Medical Profession as a Service Plan designed to give to the majority of subscribers substantially complete coverage for contract benefits, and

"'Whereas, The initial income limit of $2,400 for the family and $1,500 for a single individual per year assured service benefits to a majority of the enrolled residents of Colorado, and

"'Whereas, The service benefit feature is the principal advantage of the doctor-sponsored voluntary Blue Shield Plans; therefore, be it

"'Resolved: That Colorado Medical Services, Inc., adhere to the objective originally established and in recognition of the change in economic conditions, develop an alternate Blue Shield Plan, with a revised fee schedule and with an annual income limit of $4,500 for the family and $2,600 for the individual which will again provide substantially complete coverage to the majority of enrolled members electing the new Plan; the fee schedule for the new Plan to be approved by Medical Service Plans Committee.

"'Resolved: That these two Blue Shield Plans shall be the principal medical-surgical programs offered by Colorado Medical Service, Inc., to residents of Colorado.'

"This resolution was approved and is forwarded to the House of Delegates for action."

With respect to this section of the supplemental report of the Public Policy Committee, your committee recommends that this resolution be adopted by the House of Delegates with the following amendment: That portion of the fourth paragraph of the resolution reading as follows: ". . . the fee schedule for the new plan to be approved by Medical Service Plans Committee," be stricken, and the following language be substituted therefor: ". . . the fee schedule for the new plan to be given final approval by the Board of Trustees of the Colorado State Medical Society after consultation with the Public Policy Committee of the Colorado State Medical Society, component societies, and specialty groups." Your committee recommends that the House of Delegates request the Board of Trustees to see that such action be taken as speedily as possible.

(d) The next section of the Supplemental Report of the Public Policy Committee reads as follows:

"A report was also received from the Tuberculosis Control Committee, and a resolution concerning the use of BCG vaccine. It was the feeling of the committee on Public Policy, that no action was necessary by this committee and that the resolution be submitted as a supplemental report by the Committee on Tuberculosis Control."

Your committee approves this section of the supplemental report of the Public Policy Committee.

(e) The next paragraph of the supplemental report of the Public Policy reads as follows:

"A request was received from the University of Colorado School of Medicine concerning an opinion in permitting osteopathic physicians to attend courses presented by the Postgraduate School of Medicine. A motion was passed that it be left to the discretion of the school authorities as to who should be allowed to enroll in their postgraduate courses."

Your committee approves this section of the supplemental report of the Public Policy Committee.

(f) The last paragraph of the supplemental report of the Public Policy reads as follows:

"As indicated in our original report, a survey was made to explore the opinions of the profession in relation to the Medical Practice Act. Excellent response was obtained. The answers all supported the principles of the Act. There was some disagreement as to wording and phraseology as well as interpretation. There were very few suggestions that the Act be repealed. A summary of the statistics will be available to the Reference Committee and the letters also will be available to the Reference Committee. By motion, the committee went on record as supporting the underlying principles of the Medical Practice Act, and recommends that a joint committee, composed of representatives of the affected groups, meet for the purpose of exploring the possibilities of working within the Act; to obtain a legal interpretation and analysis of the Act; and to enable hospitals and doctors to work within the provisions of the Act."

Your committee recommends the acceptance of this section of the supplemental report of the Public Policy Committee, with the exception of the recommendation. We believe that this should be

stricken, and the following language inserted in its place:

"It is the opinion of the committee that the Act embodies fundamental principles that must be preserved. We recommend that through appropriate committees of affected groups, ways and means be explored and evolved to permit satisfactory functioning within the provisions of the present law."

WILLIAM C. SERVICE, El Paso, Chairman,
BRADFORD MURPHEY, Denver,
GEORGE F. WOLLGAST, Denver,
WILLIAM R. LIPSCOMB, Denver,
R. J. GROOM, Mesa,
CHARLES L. MASON, San Juan,
J. A. SHAND, Otero,
F. D. KUYKENDALL, Weld,
EUGENE B. LEY, Pueblo.

The above report was adopted section by section and as a whole on motions regularly seconded and passed without dissent in each case. Speaker Jones then personally thanked Dr. Service and the members of the Reference Committee on Public Relations for their long arduous work in hearing witnesses and studying the many reports referred to them.

First Report of Reference Committee on Professional Relations

Dr. Scott A. Gale, Chairman, then presented a report for the Reference Committee on Professional Relations as follows:

(a) The committee approves the report of the Board of Councilors as it appears on page 11 of the Handbook.

(b) The committee approves the report of the Delegates to the American Medical Association as this report appears in the Rocky Mountain Medical Journal, page 118, of February, 1951, and page 607, August, 1951.

(c) The committee approves the report of the Medico-Legal Committee as it appears on pages 22 and 23 of the Handbook.

(d) The committee approves the report of the Subcommittee on Nurses Education as it appears on page 30 of the Handbook.

(e) The committee approves the report of the committee on the Rocky Mountain Medical Conference as it appears on pages 46, 47, 48, and 49 in the Handbook. We agree with the continuing committee that there are too many Medical Meetings and that the Rocky Mountain Medical Conference should be held concurrently with the host State Meeting. The committee recommends the adoption of section (2) on page 48 of the Handbook as a solution to the problem of financing the Rocky Mountain Medical Conference.

(f) The committee approves the report of the Delegate and Alternate to the Colorado Interprofessional Council as it appears on page 49 of the Handbook. The Reference Committee urges that the delegate and alternate suggest to the Interprofessional Council that it reconsider its aims and functions since there are great possibilities if such a council is fully exploited.

SCOTT A. GALE, Pueblo, Chairman,
TERRY J. GROMER, Denver,
FREDRICK H. GOOD, Denver,
JOHN H. AMESSE, Denver,
D. R. COLLIER, Clear Creek Valley,
HARLAN E. McCLURE, Prowers,
C. J. BENNETT, Washington-Yuma.

The above was adopted section by section and as a whole on motions regularly seconded and passed without dissent. Chairman Gale then announced that a further and final report of the committee would be submitted at the next meeting of the House.

Second Report of the Reference Committee on Public Health

Dr. E. A. Elliff, Chairman, submitted the following report:

As directed by the House at yesterday's meeting, your committee has reconsidered the supplemental report of the Committee on Tuberculosis Control, which included a resolution that the Tuberculosis Control Committee itself had adopted in regard to the use of BCG vaccine.

Your Reference Committee believes it wise for the House of Delegates to leave questions of scientific procedures for tuberculosis diagnosis, therapy, and possible immunization to specialists in the field of Tuberculosis Control. We believe that it is not a proper function of this House, as a legislative body, to pass upon scientific questions and we understand that the Tuberculosis Committee made no such request, but on the contrary reported to us an accomplished fact. Therefore, neither approval nor disapproval of the use of BCG vaccine as a scientific procedure is implied in accepting the report of the Committee on Tuberculosis Control. Your Reference Committee recommends that the supplemental report be accepted by this House of Delegates, with the thanks of the House to the Committee on Tuberculosis Control and our confidence that the committee will continue its efforts to reduce the incidence of this disease.

E. A. ELLIFF, Northeast, Chairman,
FRANK B. McGLONE, Denver,
H. C. FISHER, Denver,
CARL H. GRAF, Boulder,
E. F. GEEVER, El Paso.

The above report was adopted on motion, seconded by several, and passed unanimously.

There was no unfinished business. No delegate offered new business.

At this point it was noted that Dr. C. H. Graf of Boulder had found it necessary to leave the meeting and that his alternate, Dr. M. L. Weiker, was present. On regular motion made, seconded, and passed without dissent, the House then seated Dr Weiker. There being no further business, Speaker Jones declared the House adjourned until 8:30 a.m., September 21, 1951.

FOURTH MEETING—Friday, Sept. 21, 1951

Speaker Jones called the House to order at 8:30 a.m. There was no further report from the Credentials Committee. Executive Secretary Sethman called the roll and announced that there were forty delegates, more than a quorum, present. The Speaker then announced the House as organized and ready for business.

On motions regularly made, seconded and passed without dissent, Dr. C. A. Rymer, alternate, was seated in place of Delegate Dr. Bradford Murphey pending Dr. Murphey's arrival in the House, and Dr. Walter E. Vest, Jr., alternate, was seated in place of Delegate H. J. von Detten, both for Denver County. Speaker Jones then introduced Mr. Robert Humphrey, Vice President, and Mr. Eakins, Secretary, of the Colorado Chapter of the Student American Medical Association who were visiting the House of Delegates meeting. Mr. Humphrey and Mr. Eakins both acknowledged the introduction.

By unanimous censent the reading of the minutes of the Third Meeting of the House was dispensed with. The next order of business was the election of officers.

Election of Officers

By direction of the Speaker, the Executive Secretary reread the report of the Committee on Nominations as submitted at the Wednesday afternoon (second) meeting of the House (see report on pages 972 and 974).

Dr. C. J. Bennett, delegate from Washington-Yuma Counties, personally addressed the Chair and asked permission to withdraw his name as a candidate for membership on the Board of Supervisors. Speaker Jones ruled that Dr. Bennett could so withdraw and declared his name withdrawn from nomination.

Speaker Jones called for further nominations for the office of President-Elect. After allowing a reasonable time for any delegate to make such a nomination and none being made, the Speaker declared the nominations closed and entertained a motion directing the Secretary to cast the

POSTGRADUATE LECTURES FOR SOUTHEASTERN COLORADO PHYSICIANS

Third Monday of each month—Mennonite Hospital and Sanitarium
La Junta, Colorado

Sponsored by Hospital Staff and the University of Colorado School of Medicine

PROGRAM

December 17, 1951

10:30 a.m.—Gastric Resection—
Kenneth C. Sawyer, M.D.

Treatment of Head Injuries—
William R. Lipscomb, M.D.

January 21, 1952

10:30 a.m.—Treatment of Burns—
Henry Swan, II, M.D.

Acute Cholecystitis—
Samuel B. Potter, M.D.

unanimous ballot of the House for Dr. William A. Liggett of Denver as President-Elect of the Society. The motion was made, seconded and carried unanimously. The Speaker then appointed Drs. George A. Unfug, Pueblo, and Fred A. Humphrey, Fort Collins, to find Dr. Liggett and escort him to the room.

Speaker Jones then proceeded by independent actions in each instance to conduct the election of all nominees submitted to the House by the report of the Nominating Committee, and there being no further nominations from the floor, the House elected those nominees in each instance except as follows in these minutes.

Following election of the three members to regular terms on the Board of Councilors the Executive Secretary announced that President Hinds had just informed him of having received a resignation from Dr. Arch H. Gould of Grand Junction, Councilor for District No. 8. Dr. Hinds announced that he had accepted the resignation, thus leaving a one-year vacancy on the Board of Councilors for the Councilor representing District No. 8. Speaker Jones referred these facts to the Nominating Committee and asked for an immediate meeting of that committee and a report.

At this point, Drs. Unfug and Humphrey escorted Dr. William A. Liggett to the rostrum. Dr. Liggett addressed the House as follows:

"Mr. Speaker and members of the House: Ever since I heard this might happen I have been scared to death, and now it has happened I am no less upset about it. Added to fright, there are other mixed emotions, which you can understand. I think the best thing for me to do to express my predicament is to tell you of the very inebriated gentleman who had fallen into a deep well and he said, 'How in the hell did I get up here?' " (Applause).

Speaker Jones then called for any further nominations for positions on the Board of Supervisors, in addition to those submitted by the component societies and the Nominating Committee.

Dr. Jackson L. Sadler, Larimer County, was nominated by Dr. Kenneth C. Sawyer.

Dr. Lawrence D. Buchanan, Washington-Yuma Society, was nominated by Dr. Frank B. McGlone.

There being no further nominations the Speaker declared the nominations closed and appointed Drs. E. P. Sheridan and J. B. Grow as tellers to collect ballots. There were ten nominees for the six positions vacant on the Board. While delegates were marking their ballots Speaker Jones proceeded to conduct the elections of the Delegate to the A.M.A., Alternate Delegate, Foundation Advocate, Speaker and Vice-Speaker of the House in the manner heretofore set forth.

Special Report of the Nominating Committee

Dr. L. E. Thompson, chairman, presented a special report for the Nominating Committee placing in nomination the name of Dr. Harvey M. Tupper of Mesa County for a one-year term on the Board of Councilors to fill the vacancy created by the resignation announced earlier this morning. The Speaker asked for but received no further nominations from the floor for this position, declared the nominations closed, and on motion regularly made, seconded and carried unanimously, the Secretary was instructed to cast the ballot of the House for Dr. Tupper for this position.

Election of Board of Supervisors

The tellers reported to Speaker Jones the results of their count of ballots and the Speaker announced that by its vote the House of Delegates had elected Drs. Buchanan, Sadler, Cary, McCarty, Anderson and Myers as the six new members of the Board of Supervisors for the ensuing two-year term.

Mr. Sethman asked instructions from the House as to whether the recommendation of the Nominating Committee for investigation of the possibility of the Broadmoor Hotel in Colorado Springs as a site for the 1954 Annual Session should be considered a definite instruction to arrange such a meeting if it can be done. He pointed out that by previous action of the House the Society now schedules its annual sessions two years in advance but that if this were a definite instruction for 1954 it might be considered an instruction three years in advance.

The question of long-term advance scheduling of conventions was then discussed by Dr. L. E. Thompson, chairman of the Nominating Committee; T. J. Gromer, A. D. Waroshill, L. T. Brown, Frank B. McGlone and the Speaker, following which on motion by Dr. Gromer, amended by Dr. Brown (both the motion and the amendment being regularly seconded and passed without dissent) the Executive Secretary was instructed to make definite arrangements with the Broadmoor Hotel for the 1954 meeting or the first possible meeting thereafer.

Dr. Mahan then moved that the Nominating Committee of the House of Delegates in the future be instructed to plan annual session locations three years in advance. The motion was regularly seconded and carried unanimously. On regular motion, seconded and carried without dissent the report of the Nominating Committee as amended was then adopted as a whole.

Second Report of the Reference Committee on Professional Relations

Dr. Scott A. Gale, chairman, announced that the Reference Committee on Professional Relations was ready to submit its final report but that the committee first wished to have an executive session of the House for preliminary discussion. On motion, duly seconded and carried without discussion or dissent, the House then went into executive session. On arising from executive session Dr. Gale read the following report of the Reference Committee:

Your committee has considered the report of the Board of Supervisors as published on pages 11 and 12 of the Handbook and approves the report. Also, your Reference Committee has consulted with many officers and members of the Society, including some former members of the Board of Supervisors, concerning operations of that Board within the last year. Your Reference Committee has been deeply concerned and disturbed by the evident fact that in the past some members have been elected to the Board of Supervisors, without their full appreciation of either the responsibilities or the difficulties of the positions they were about to undertake.

Your Reference Committee is of the opinion that some of our County Societies have not given the study and thought to the selection of nominees for the Board of Supervisors which the truly terrific responsibilities of this Board require. Your Reference Committee therefore offers the four following recommendations:

First: We ask each delegate to take home to his County Society, our urgent request that the responsibilities and functions of the Board of Supervisors be thoroughly discussed within this next year so that nominees presented to next year's House of Delegates will be fully aware of the task that they may undertake, as well as being members with the highest sense of public and professional responsibilities.

Second: We recommend that the Board of Trustees, in consultation with the Board of Supervisors, and if necessary the Board of Councilors, carefully study the Society's Constitution and By-Laws with a view of possibly submitting amendments to our By-Laws next year designed to improve the method of selection of members of the Board of Supervisors

so that the Society may be assured in the future that its Board of Supervisors will be made up of men willing to undergo the personal sacrifices necessary to the maintenance of the highest possible standards for this Board. We make this recommendation with the belief that the House of Delegates will agree with your Reference Committee that the proper functioning of our Board of Supervisors is the most important single activity in the Public Relations program of the Colorado State Medical Society among its extra-scientific activities.

Third: We recommend that the President of the Colorado State Medical Society (or his representative) be present at the organizational meeting of the Board at which time the Board of Supervisors will become fully acquainted with the responsibility they hold in discharging their office to the people of the State of Colorado and the members of the Colorado State Medical Society.

Fourth: We recommend that the Board of Trustees consider the possibility of the payment of transportation to the meetings of the Board of Supervisors.

SCOTT A. GALE, Pueblo,
Chairman,
TERRY J. GROMER, Denver,
FREDRICK H. GOOD, Denver,
JOHN H. AMESSE, Denver,
D. R. COLLIER, Clear Creek
Valley,
HARLAN E. McCLURE, Prowers,
C. J. BENNETT, Washington-
Yuma.

On motion of Dr. Gale, seconded by several, the above report was adopted unanimously, without discussion. Speaker Jones then commended the Reference Committee on Professional Relations, for himself and for all other members of the House, for what he referred to as "a very strong and brave report," and the Speaker asked Chairman Gale to convey the official thanks of the delegates and the Chair to all other members of his committee.

There was no unfinished business on the desk. Under the order of new business Dr. Amesse addressed President Hinds and asked that the President of the Society officially commend the Speaker and Vice-Speaker of the House for the excellent and efficient manner in which they had handled these four meetings. Constitutional Secretary Buck made the motion that a special vote of commendation be extended to the Speaker and Vice-Speaker. It was seconded by many. President Hinds assumed the Chair, called for discussion, of which there was none. He then placed the motion which was unanimously carried, following which all delegates arose and applauded Drs. Jones and Hildebrand. Speaker Jones reassumed the chair and thanked the delegates on behalf of Dr. Hildebrand and himself. He also thanked all delegates for their attendance and for their work on reference committees throughout the last four days.

There being no further business, Speaker Jones declared the House of Delegates adjourned without day.

Respectfully submitted to the Society,

HARVEY T. SETHMAN,
Executive Secretary, Secretary
of the House of Delegates.

Obituaries

HAROLD ROBERT CARTER

Dr. Harold R. Carter was born in Battle Creek, Michigan, April 11, 1907, and died from an automobile accident which occurred near Casper, Wyoming, October 28, 1951.

He received his pre-medical work at Emmanual Missionary College, Berrien Springs, Michigan, and took his degree in medicine on June 16, 1932, from the College of Medical Evangelists.

After graduation, he practiced medicine in San Diego, California, from 1933 to 1935, after which he joined the Army Medical Corps and served with the armed forces from 1937 to 1942. He came to Denver and was elected to membership in the Colorado State Medical Society on February 5, 1943, and was associated with Dr. C. S. Bluemel in the practice of neuropsychiatry.

He was a diplomate of the American Board of Psychiatry. He was a member of the National Regional Medical Society, the American Medical Association, the Medical Society of the City and County of Denver, the Colorado State Medical Society, the Colorado Neuropsychiatric Society, the American Psychiatric Association, the American Society for Research in Psychosomatic Problems.

Dr. Carter is survived by Mrs. Esther C. Carter, his wife; and two children, Donna and Ronald; and a brother, Raleigh Carter, of Battle Creek, Michigan.

WILLIAM HENRY CRISP

Dr. William H. Crisp was born in London, England, October 4, 1875, and died at his home in Denver, Colorado, October 17, 1951. Educationally, he was one of Colorado's medical sons, having received his degree in medicine from the Denver and Gross College of Medicine in June, 1907. He was licensed to practice medicine both in Colorado and New Mexico, but was an active member of the Colorado State Medical Society since 1911. He not only specialized in ophthalmology, but because of his medical writings and editorial work along this line, he became well known throughout America. Aside from the merits of his scientific contributions, he was a purist in diction with a style of great literary force.

Aside from his regular work, he was a member of the Colorado Ophthalmology Society, the American Ophthalmology Society, the American College of Surgeons, and other scientific bodies. He was editor of the Ophthalmic Year Book from 1923 to 1927, and editor of the American Journal of Ophthalmology from 1927 to 1931, remaining consulting editor for that journal until his death. He added materially to the editorial policies of "Colorado Medicine" (predecessor to the "Rocky Mountain Medical Journal") from 1914 to 1919.

Survivors are his wife, Mrs. Katharine Crisp, of Denver; a daughter, Mrs. Nancy Hartsfield, and two grandsons, John and Robert Hartsfield, both of Denver.

MAURICE LEVY, M.D.

Dr. Levy was born in Philadelphia, Pennsylvania, in the year 1890, and passed away in Colorado on November 14, 1951.

He graduated from the University of Toronto Faculty of Medicine in 1912. He came to Colorado and obtained his license for membership in 1919 and was elected to membership in the Colorado State Medical Society in 1920.

He was a member of the staffs of Mercy and General Rose Hospitals and was an active member of the County and State Societies and the Colorado Society of Internal Medicine. He was a Mason, a Shriner, and a member of the Legion, Leyden-Chiles-Wickersham Post, and Temple Emanuel.

He is survived by his wife and a stepson.

NORTHEAST COLORADO MEDICAL SOCIETY

At the November 8 meeting of the Northeast Colorado Medical Society Drs. Frank M. Means, Clarence J. Latta, John W. Kinzie, Edward P. Hummel, and James H. Daniel were elected to emeritus membership in this Society. The Northeast Colorado Medical Society voted to give each emeritus member a subscription to the Rocky Mountain Medical Journal.

WANTADS

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WYOMING
State Medical Society

48th ANNUAL MEETING
WYOMING STATE MEDICAL SOCIETY
Rock Springs, Wyoming
September 27, 28, 29, 1951

PROCEEDINGS

Sweetwater County Medical Society was host to the Wyoming State Medical Society during its 48th Annual Meeting held in Rock Springs, September 27, 28, 29, 1951. Dr. J. G. Wanner, President of the Sweetwater County Medical Society, extended welcome to all Delegates and expressed pride that the Sweetwater Medical Society had been able to secure such outstanding men in the medical profession to head the scientific sessions, and special pride in having as the main speaker Dr. John Cline, President of the American Medical Association. An official welcome was then extended the group by Mr. Edwin E. James, Mayor of the City of Rock Springs. The meeting was then turned over to Dr. Karl E. Krueger, President of the Wyoming State Medical Society.

Dr. Krueger opened the meeting for business. It was moved, seconded and voted that the rules be suspended and that the election of officers be deferred until the last meeting of the session. Dr. Krueger then appointed three committees necessary to the meeting. The committees were: Credentials Committee, Dr. Wilmoth and Dr. Sampson; Time and Place Committee, Dr. Holtz, Dr. Dominick and Dr. Wilmoth; Resolutions Committee, Dr. Sampson, Dr. Reeve, Dr. Yoder and Dr. Guilfoyle. President Krueger indicated that he wished to appoint a delegate from Rawlins to one of the committees but that none were present.

Rocky Mountain Medical Conference

Dr. Earl Whedon of Sheridan led a discussion concerning the location of meetings of the Rocky Mountain Medical Conference and the financing of these conferences. Dr. Whedon then made a motion that the House of Delegates express its protest against any movement to discontinue the original plan of meeting in Wyoming once every ten years, and that it pledge itself to take care of the conference financially and in the way of housing. Dr. Sampson seconded the motion, and it was carried unanimously.

It was moved that the Wyoming State Medical Society subscribe to a Rocky Mountain Medical Conference fund at the same rate per member as the other State Societies. This motion was seconded and carried unanimously.

Dr. Whedon read the names and gave a brief history of the following doctors who passed away during the year since the 47th Annual State Medical Society Meeting. They were: Dr. Orlay Edward Plummer, Dr. Earl George Clegg, Dr. William Donald Harris, Dr. John Russel Newnam and Dr. Roy Asquith Ashbaugh. After this reading all stood for a moment of silent respect for those doctors.

Dr. Yoder reported on a meeting of the Editorial Staff of the Rocky Mountain Medical Journal which was held in Denver in May, 1951. The hope was expressed that more scientific papers and case reports would be submitted for the Journal from the Wyoming medical profession.

September 28, 1951—8:00 a.m.

It was requested by Dr. Krueger, President, that the first order of business be the report from the Credentials Committee. Dr. Wilmoth gave this report as follows:

Designation of Delegates: Albany County—Drs. B. J. Sullivan and E. C. Pelton; E. W. DeKay, Ex-Officio. Fremont County—Drs. P. R. Holtz and L. H. Wilmoth. Goshen County—Drs. L. B. Keenan; L. B. Morgan and J. B. Krahl, alternates. Laramie County—Drs. J. B. Gramlich, S. S. Zuckerman, P. R. Teal and S. J. Giovale. Natrona County—Drs. K. N. Roberts, N. E. Morad, Joe Clark, G. U. Motter; R. H. Reeve, Ex-Officio. Northeast Medical Society—Drs. E. J. Guilfoyle; Joe Hoadley, alternate. Northwest Medical Society—Drs. DeWitt Dominick and J. A. Gausch. Sheridan County—Drs. J. W. Sampson and O. L. Veach; Earl Whedon, Ex-Officio. Sweetwater County—Drs. Richard Stratton and Paul Kos. Uinta County—Drs. Blair Liddell; J. H. Holland, alternate.

A motion to accept the Credential Committee's report was made, seconded and voted unanimously.

It was moved, seconded and voted that since the minutes of the 1950 State Medical Society Meeting were published in the December issue of the Rocky Mountain Medical Journal, that the reading of them be dispensed with.

Reports of Committees

Dr. Yoder reported on the progress of the committee on the Gottsche Estate gift for a polio hospital at Thermopolis. A committee meeting with Dr. W. S. McClellan, Medical Director of the Saratoga Springs Commission, was held this year, and it is believed that the people of Thermopolis will be more cooperative when they realize that physicians like Dr. McClellan believe that the hot springs are good and worth developing. The committee report indicated that the executors of the estate were willing to do what the medical profession thought best, with respect to this hospital. It was moved, seconded and voted that the report be accepted.

Dr. Wilmoth presented the report of the Syphilis Committee. The report indicated that the Syphilis Committee had not been confronted with any special problems requiring action, and that the incidence of syphilis in Wyoming continued to show decline. Syphilis in Wyoming is not considered a major health problem. The only significant changes in treatment, the report stated, are the tendency toward larger doses of penicillin and the use of terramycin in conjunction with penicillin in difficult cases. It was moved, seconded and voted that the report be accepted.

Dr. Gramlich, chairman of the Cancer Committee, presented his report. The report of the Cancer Committee indicated that its work of service, education and research is being continued and that it is paying its own way. The relationship of the Cancer Society and organized medicine was stressed with the following points: (1) There are several volunteer health organizations but the only one actually supervised or controlled by organized medicine is the Cancer Society, which has an equal number of doctors and lay representatives on the Board of Directors. (2) The organization of the Cancer Committee of the State Medical Society and the

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Board of Directors of the Cancer Society go hand in hand, with the five members of the Cancer Committee being automatically on the Board of Directors of the Cancer Society. It was suggested that the State Medical Society set up its Cancer Committee so that one member would go out each year, replaced by a new member. Thus, the Cancer Committee would be stabilized with its members serving five years. The report stated that because of the death of Dr. Newnam and the resignation of Dr. Henrich, two new members had been appointed. These two new members are Dr. Krueger and Dr. Gitlitz. It was moved, seconded and voted that this report be accepted.

Dr. Teal presented the Fracture and Industrial Health Committee report. The report stated that State Compensation records make it difficult to catalog industrial accidents and to get facts and figures. An attempt will be made to set up a cataloging index so that the committee can get an idea of the most common type of industrial accident, most common type of fracture, time lost from work and other pertinent facts. It was moved, seconded and voted that the report be accepted.

Dr. Koford reported that there were no transactions by the Medical Defense Committee. He reported that the fund of $10,000 was subject to income tax, and also expressed the opinion that, since the fund has kept the state practically free of malpractice suits, it is well worth the money.

Following Dr. Koford's report, it was explained by Dr. Whedon that the Medical Defense Fund was set up to defend a doctor involved in a malpractice suit when the committee is convinced that he is in the right, and summarized the procedure that a doctor should follow to get help from the committee. If threatened with a malpractice suit, the doctor should notify the Medical Defense Committee, and the Secretary will send him a questionnaire. This questionnaire should be completed and filed with the county committee or if there is no county committee, with the state committee. A special committee will then be appointed to go over his case, and the doctor involved should be sure to give it complete information. The committee will then send its recommendations to the State Medical Defense Committee. If request for help is approved, one-third of the fund will be given to the doctor for his defense. It was moved, seconded and voted that the Medical Defense Committee report be accepted.

Dr. Zuckerman presented the report of the Advisory Committee to Selective Service on Procurement and Assignment of Physicians. The committee had no special problems due to the fact that the law is clear and interpretation easily made. It was noted that the only doctors in category 1 were being called at the present time. Of the nine Wyoming doctors in this category, five volunteered and are on active duty. No doctor had been inducted. The total expenses were in the neighborhood of $100.00. It was moved, seconded and voted that the report be accepted, and that Dr. Zuckerman be commended for the good work he had done.

Report of the Council

Dr. DeKay presented the Councilors' Report. Three meetings of the Councilors were held—one in January, one in February and one in September. At the January meeting with all Councilors present, a proposal to establish a School of Nursing at the University of Wyoming was approved; Dr. Yoder was appointed head of Civilian Medical Defense for Wyoming; the Public Health Enabling Act was approved. Since Dr. Sullivan, who had been elected Alternate Delegate to the American Medical Association, was ineligible, Dr. Bunten was appointed in his place. It was decided that if a man misses a year in payment of dues, that payment for that year must be made before the doctor can be paid up to date and on a current basis.

At the February meeting with a majority present, the non-participation of Carbon County physicians in the Blue Shield Plan was discussed; a special trip to Rawlins was made to ask them to come in, but with no result.

At the September meeting with a majority present, the Northeastern Wyoming Medical Society was granted a charter. The Treasurer's and Executive Secretary's reports were audited and approved; the 1951-52 budget was approved. It was decided that the President-Elect should be invited to each and all Councilors' meetings. It was moved, seconded and voted that the report be accepted.

Dr. Koford reported for the Veterans' Affairs and stated that Dr. Burnett and Dr. Pearce from the Veterans' Hospital at Cheyenne would speak at the Wyoming State Medical Society meeting on "Veteran's Medical Benefits at His Home Town," and that the military angle had been turned over to Dr. Zuckerman's committee.

Blue Cross and Blue Shield

Dr. Sampson read the report of Blue Cross, which was prepared by Dr. Russell I. Williams, President of the Board of Trustees, Wyoming Hospital Service. The report presented several new programs, approved by the Executive Committee, and planned for approval by the Board of Trustees at the next meeting, October 4. (1) Preferred Blue Cross Contract—Room allowance $8.00 per day, with seventy days coverage per admission and unlimited ancillary services. (2) Standard Blue Cross Contract, being the present contract broadened to include seventy days care per illness and an unlimited drug and oxygen allowance. (3) Individual enrollment program—the Standard Contract with health statements and a higher rate, available to unemployed and those employed in groups of less than five.

All groups presently enrolled will be converted to the new Standard Contract or the new Preferred Contract. An adjustment in rates to cover rising hospital costs and increased benefits will be made at the same time the new programs are put into effect.

Enrollment in the Blue Cross program has grown to nearly 60,000, and with the addition of the new contracts and the new rates the plan should remain financially stable. It was pointed out in the report that if physicians will do everything in their power to help Blue Cross to cover more Wyoming people and to help it by not hospitalizing people unnecessarily and by not keeping patients in the hospital a day longer than is necessary, Blue Cross will continue to carry on the bulwark of the fight against socialized medicine by providing a voluntary program of hospital services. It was moved, seconded and voted to accept Dr. Williams' report on Blue Cross as read.

It was noted by Dr. Sampson that there were two vacancies on the Board of Trustees of Wyoming Blue Shield, and suggested that in order to fill these vacancies there should be recommendations from the floor. A motion that Dr. Guilfoyle be recommended by the State Medical Society to fill one of the vacancies on the

Board of Trustees was made, seconded and carried unanimously.

Dr. Koford presented the report of the Public Policy and Legislation Committee. He reported that the Naturopath Bill had been defeated but pointed out that if it is to be avoided and the Medical Practice Act revised, the doctors must do some public relations work at home, asking their patients to write to their legislators in order to counteract the flood of mail sent by a few people at the request of the Naturopaths. The committee felt that a Basic Science Law is unnecessary and unworkable and that revision of the Medical Practice Act is all that is necessary. It was moved that the doctors in Cheyenne be commended for the fine work they have done for the Society, and that the report be accepted. The motion was seconded and carried by unanimous vote. Dr. Whedon stated an opinion that revision of the Medical Practice Act would protect the people from quacks, and moved that the House of Delegates declare itself not in favor of a Basic Science Act. The motion was seconded and carried unanimously.

There was no report from the State Institutions Advisory Committee, Public Health Department Liaison Committee, Rural Health Committee, the Child Health Committee, nor the Council on National Emergency Medical Service. There was no report from the Judicial and Advisory Committee nor the Corresponding Secretary. Dr. Drew, Dental Director for Civilian Defense in Wyoming, briefly explained the Medical Civilian Defense organization.

Dr. Koford presented the Blue Shield report. This report began with an expression of extreme gratitude to the Trustees who have given unstintingly of their time and efforts to the Blue Shield program. The plan's sound financial status was highlighted and it was pointed out that the $100.00 loan made to the plan by each participating physician had been returned. In-hospital coverage was added during the year, and individual enrollment is planned for the coming year. Thirty-six thousand Wyoming people were covered under Blue Shield at the time the report was made. It was urged that each doctor talk Blue Shield to his patients, that being the best means of obtaining new subscribers. It was pointed out that the Administrative Staff of the program hoped to meet with County Societies and answer questions concerning its operation and be helpful in any way possible. The report closed with thanks for past cooperation and hopes for a bigger and better Blue Shield program for the people of Wyoming, for the benefit of the public, the doctors and the hospitals. It was moved, seconded and voted that the report be accepted as read. It was moved, seconded and voted that an individual copy of the Blue Shield report be sent to each doctor in Carbon County.

Mr. Abbey, Executive Secretary, Wyoming State Medical Society, introduced Dr. Noyes of Dixon, Wyoming, who came to Wyoming and started practice in 1899.

September 29, 1951—8:00 a.m.

The first order of business was the reading of the Treasurer's report by Dr. Whedon.

The report listed money received and disbursed from January 1, 1950, to January 1, 1951. The General Fund consisted of assets totaling $12,178.85. During the year there were total disbursements amounting to $8,575.03, plus outstanding checks totaling $49.85, less a deposit on January 3, 1951, of 1951 income in the amount of $31.25, making a grand total of $8,593.63. As of January 11, 1951, there was cash in bank of $3,585.22, making a total of $12,178.85 and balancing the cash receipts. There were no receipts and no disbursements of the Medical Defense Fund during the year, and the cash balance as of January 11, 1951, was $657.97, the same as for January 1, 1950.

In summary, January 1, 1951, the General Fund consisted of cash on hand, $4,243.19; United States bonds, $5,500.00, making a total of $9,743.19. In the Medical Defense Fund there was cash on hand of $657.97 and United States bonds in the amount of $9,500.00, making a total of $10,157.97, or a grand total of $19,901.16 resources. A motion to accept the report was seconded and voted unanimously.

Dr. Krueger presented the President's report, and it was moved, seconded and voted that this be published in the Rocky Mountain Medical Journal.

The next order of business was the election of officers.

Election of Officers

Dr. Sampson of Sheridan and Dr. Guilfoyle of Newcastle were nominated for President-Elect. It was moved that nominations be closed, and Dr. Guilfoyle was elected for the office of President-Elect by a secret ballot. The following officers were then elected by unanimous decision of the group. Dr. Sampson for the office of Vice President; Dr. Koford for the office of Corresponding Secretary; Dr. Schunk for the office of Treasurer; Dr. Krueger as one of the Councilors; Dr. Krueger as member of the Medical Defense Committee. It was moved, seconded and voted that the election of the Blue Cross Hospital Committee member be deferred until a later date.

It was moved that the Advisory Committee to Selective Service on Procurement and Assignment of Physicians be re-elected intact. It was seconded and carried unanimously.

It was reported by Dr. Whedon that the Auditing Committee had carefully checked over the accounts of the Treasurer and Secretary, and found them to agree. It was moved, seconded and voted that the report be accepted as made. It was then moved that the House of Delegates request that the Treasurer report from January 1, 1951, to January 1, 1952, and then provide a supplementary report from January 1, 1952, to the time of the meeting next year. This motion was seconded and carried.

After considerable discussion of the Judicial and Advisory Committee, it was moved that the original committee as set up by the House of Delegates in districts be abolished, and that the incoming President be authorized to appoint a new committee of three or four, that the name be changed from the "Judicial and Advisory Committee" to "The Committee for Professional Review," and that each county be requested to set up a committee in its society where county societies exist. This motion was seconded and carried. Publicity for this committee was left to the Corresponding and Executive Secretaries.

Dr. Sampson presented the following resolutions, all of which were seconded and carried unanimously.

Resolutions

Whereas, We have had an excellent meeting and been entertained most graciously in Rock Springs; be it therefore

Resolved, That the Sweetwater County Medical Society be thanked for its gracious hospitality and praised for the high caliber of the meeting held in Rock Springs, September 27, 28, and 29.

Whereas, We have enjoyed the B.P.O.E. Hall

and the use thereof during our Forty-Eighth Annual Meeting; be it therefore

Resolved, That the Elks Lodge of Rock Springs, Wyoming, be thanked for extending to us their privileges.

Whereas, The Medical Practice Act of Wyoming is fifty years old, and

Whereas, An endeavor to place a more suitable Medical Practice Act six years ago met with defeat in the legislature; be it therefore

Resolved, That the State Medical Society through the appropriate committee begin work at once on the preparation of a completely revised Medical Practice Act to be proposed at the next session of the State Legislature.

It was suggested by Dr. Dominick that copies of the above resolution and copies of the present existing law be sent to County Medical Societies.

Whereas, Wyoming has had no practicing psychiatrist until September 1, 1951; and

Whereas, A partial survey made in the public schools of Wyoming to determine the number of children who were maladjusted or who were having problems sufficiently severe to need special help and guidance indicated that 6½ per cent of the 17,175 children surveyed were in need of psychiatric help; and

Whereas, Said psychiatrist will be available to all physicians of the state for psychiatric consultation and referral of cases which otherwise have to be sent out of the state; be it therefore

Resolved, That the Wyoming State Medical Society approve a mental health program in the State Health Department.

Whereas, The Wyoming State Dental Association, the Wyoming State Department of Public Health, United States Public Health Service, American Public Health Association, have recognized controlled fluoridation of communal water supplies has been found to be as effective in reducing the incidence and prevalence of dental caries among children as does water naturally containing fluorides; be it therefore

Resolved, That the Wyoming State Medical Society recommend the fluoridation of public water supplies within the State of Wyoming, for the partial control of dental caries where such a program can meet and maintain the standards recommended by the State Board of Health. Be it further

Resolved, That copies of this resolution be forwarded to the Wyoming Department of Public health and the Wyoming State Dental Association, and further, that this resolution be entered into the minutes of this meeting.

Following the resolutions, Dr. Holtz reported for the Time and Place Committee, recommending that the next meeting be held in Lander, time to be selected at a later date. The report was accepted.

Dr. Roscoe H. Reeve reported on two national meetings attended by him, one at Cleveland and one at Atlantic City.

It was brought to the attention of the group that the House of Delegates had been pressed for time in regard to its business sessions for the last three years and suggested that more time be allotted. It was generally approved that one evening's entertainment be deleted from future programs, allowing the Delegates this time. It was moved, seconded and passed that the Council be requested to investigate and

set up a program for donation to the American Medical Association Education Fund.

Dr. Holtz then addressed the group briefly, and expressed his desire to make the coming year a success and called for cooperation of all concerned.

There being no further business, the meeting adjourned.

NEWS NOTE

Dr. C. H. Platz, who has practiced in Casper since 1922 and was licensed in Wyoming in 1907, has announced his retirement. He will turn his practice over to M. C. Henrich. He practiced in Torrington from 1907 to 1922 and built the first hospital there. We particularly remember Dr. Platz in Torrington because he was our family physician there. Dr. and Mrs. Platz, both of whom have contributed much in Wyoming, will be missed. They plan to live at Fort Collins, Colorado. F.D.Y.

NEW MEXICO
Medical Society

Obituary

MEYLER D. GIBBS

Meyler D. Gibbs, M.D., Santa Fe, died October 23, 1951, in a Santa Fe hospital, after an illness of three months. Dr. Gibbs was born in 1869, and graduated from the College of Physicians and Surgeons, Keokuk, Iowa, in 1897. He had practiced in New Mexico since 1904.

He represented Harding County in the State House of Representatives from 1937 to 1940.

Dr. Gibbs was a member of the Santa Fe County Medical Society, the New Mexico Medical Society, and the American Medical Association. In 1950 he was elected to Emeritus membership in the State Medical Society.

UTAH
State Medical Association

L. WESTON OAKS

Meet your 1951-1952 President!

Dr. L. Weston Oaks was born at Vernal, Utah, June 14, 1892. He attended public schools in Vernal, Brigham Young University at Provo, Utah, University of Utah, Jefferson Medical College of Philadelphia (M.D.), University of Pennsylvania Graduate School, New York Postgraduate Medical School, and University of Vienna.

Dr. Oaks married Jessie Nelson, June 2, 1915, and has four children, three daughters and one son. He received his M.D. degree in 1919, was certified by the American Board of Otolaryngology in 1927, and by the American Board of Ophthalmology in 1939. He is a Fellow American College of Surgeons, Fellow American Academy of Ophthalmology and Otolaryngology, Member World Medical Association, Member Academy International of Medicine, Member American Academy of Applied Nutrition, Member Pacific Coast Oto-Ophthalmological Society, Member Intermountain Oto-Ophthalmological Society, Member Utah State Medical Association, and Member Utah County Medical Society.

Auxiliary

REPORT OF THE AUXILIARY TO THE UTAH STATE MEDICAL ASSOCIATION

Auxiliaries in the State have been very active this fall, with some events particularly outstanding. Utah County opened a Fashion Show for the benefit of the Sound System at the Mental Hospital in Provo. Also of interest was the immunization program, under the direction of the National Polio Foundation, with Dr. William Hammon of the University of Pittsburgh as chief in charge of operations. The members of the Utah County Auxiliary not only assisted as voluntary clerical workers, but each was asked to be responsible for herself and one other as workers in this polio experiment. Five thousand injections were given, and television shows of the clinics were shown. Mrs. Don C. Merrill, a member of the Utah County Auxiliary, is chairman of the Volunteer Services for the American Red Cross, and has done much in the blood-procurement campaign in Utah County. The railroad blood donation car was in Provo for five days, and Mrs. Merrill and her committee scheduled the doctors in the county for every hour, five hours per day, during the entire stop of the train. Others were placed on call, if needed. The 10,000th pint of blood was taken on this car while it was in Provo. A national broadcast of the work of this train was also given here. Five hundred fifty-four pints of blood were taken in Utah County alone.

The Carbon County Auxiliary was also active in assistance to the blood train. Eighty-four pints were taken from Helper in one day, and this little town has a population of less than 2,000. In Price, Utah, with a population of around 5,000, 112 pints were taken in the two-day stop of the train. Auxiliary members, under the direction of Mrs. W. W. Barrett and Mrs. Mark Jensen, handled all arrangements.

The Salt Lake County Auxiliary was host to the State Officers and Committee Chairmen at its October 15 luncheon held in the Ladies Literary Club in Salt Lake City, Mrs. L. C. Warenski, presiding. Dr. Owen Heninger, Superintendent of the State Mental Hospital, was the first speaker. He told briefly of the needs at the institution, and urged the ladies of the Auxiliary to assist in the betterment of conditions there. The Salt Lake County Auxiliary gave another $300 to the Sound System fund at the institution. The next speaker was Dr. John Bowers, Dean of the Utah Medical School, who spoke on Atomic Medicine. He gave interesting data on the atomic bombs—the immediate medical effects, as well as the delayed effects, and concluded by giving peace-time application of atomic energy. Mrs. Russell Smith of Provo then introduced her State officers and committee chairmen, and explained briefly plans for the coming year. Mrs. Smith told why the dues had to be raised, and said she felt each Auxiliary member had a right to know where the money went in the State. Mrs. Smith said she hoped each Auxiliary would push the sale of Today's Health, and the Nurse Recruitment program in all their meetings.

MRS. CLAUDE L. SHIELDS,
Publicity Chairman.

COLORADO
Medical School Notes

POLIOMYELITIS AND OTHER CHILDHOOD DISEASES WITH RESPIRATORY DYSFUNCTION

January 17, 18, and 19, 1952

Clinical Amphitheater—Dr. Florence R. Sabin Building

THURSDAY—JANUARY 17, 1952

9:00 A.M.—Registration.
9:30-10:15—Epidemiology of Poliomyelitis.
10:15-10:45—Diagnosis of Polio.

Intermission

11:00-11:30—Differential Diagnosis.
11:30-12:15—Orthopedic Management of the Polio Patient.

Lunch

1:15-2:00 P.M.—Pulmonary, Physiology and Resuscitation of the Newborn.
2:00-2:40—Resuscitation in Comatose States—Poisonings, Suffocation, Intercranial Diseases.
2:40-3:30—Psychological Reactions in Polio.

Intermission

3:40-4:20—Physical Medicine in Polio.
4:20-4:50—General Medical Care of the Polio Patient.
4:50-5:20—Neuro-Muscular Diseases with Respiratory Dysfunction.

FRIDAY—JANUARY 18, 1952

9:00-9:40 A.M.—Alterations in Respiratory Physiology in Polio.
9:40-10:00—Applicable Pulmonary Function Tests.

Intermission

10:10-12:00—Treatment of Bulbar - Respiratory Forms of Polio.
(a) Definitive Diagnosis and Management of Specific Types; Use of Respirators.
(b) Use and Demonstration of Electrophrenic Stimulator and Oscillating Bed.
(c) Techniques in Management of the Bulbar Case—Tracheotomy, Bronchoscopy.

Lunch

1:00-1:45 P.M.—Preparation of a Child for Anesthesia.
(a) Pre-medication.
(b) Consideration and Management of Emotional Factors.
1:45-2:40—Surgical Diseases of the Chest in Infants. (Problem Cases With Class Participation).

Intermission

2:50-3:20—Choice and Use of Anesthetic and Resuscitative Agents in Children.
3:20-3:50—Foreign Bodies in the Pulmonary Tract.
3:50-4:20—Ateleclasis in Pulmonary Tuberculosis.
4:20-5:00—"Sudden Death"—Common Causes in Infancy and Childhood.

SATURDAY—JANUARY 19, 1952

Demonstrations in Polio Patient Care

9:00-10:30 A.M.—Nursing.
10:45-12:00—Physical Therapy.

Guest speakers will be: (1) Dr. James L. Wilson, Professor of Pediatrics and Communicable Diseases, University of Michigan, Ann Arbor, Michigan; (2) Dr. James L. Whittenberger, Professor of Physiology and Head of Department, School of Public Health, Harvard University, Boston, Massachusetts.

Tuberculosis Abstracts

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OBSTACLES TO THE ERADICATION OF TUBERCULOSIS

James Perkins, M.D., A Lecture Endowed by Michigan Tuberculosis Association, December 4, 1950.

There has been widespread publicity and jubilation over the drop in the tuberculosis death rate from the peaks of about 200 deaths per 100,000 population at the turn of the century to the provisional death rate of 26.1 for 1949.

It is good news! Unfortunately many have the impression that tuberculosis is a problem that is already solved. Yet tuberculosis is the principal communicable disease for the world as a whole. It is estimated that between 3,000,000 and 5,000,000 people die each year throughout the world from tuberculosis. Even in the United States, it causes nearly 40,000 deaths per year. It is the chief cause of death in the United States in the important child-bearing and child-rearing ages of 15 to 34. Because so many people die from tuberculosis in the prime years of life, it causes a potential loss of years of life approximately equal to cancer, and not far behind the combination of diseases called "heart diseases." Today, more cases of tuberculosis are known than ever before, due largely to our improved case-finding programs, and there is good reason to believe that the death rate is dropping faster than the prevalence of tuberculosis. Although eradication is the objective of all voluntary and official health agency workers concerned with the tuberculosis problem, eradication is still a long way off.

There are many obstacles to be overcome—obstacles closely related to the four basic activities in tuberculosis control, namely, case finding, treatment, increasing human resistance to tuberculosis, and research. For these activities, numerous tools and technics are needed. Some of these are an adequate number of trained personnel, adequate physical facilities, health education, laws and regulations, record systems and statistical analyses, and adequate financing.

The chest x-ray of the apparently well adult is probably the most important aspect of case finding. While the annual physical examination, including a chest x-ray, for every adult is still advised, a more practical goal from the standpoint of tuberculosis control is the annual chest x-ray without the complete physical examination. In a series of fast-tempo, short period, large city chest x-ray campaigns since 1947, over 4,000,000 people have been x-rayed. This is a remarkable undertaking. In these campaigns, about 0.3 per cent significant tuberculosis has been discovered and most of them were previously unknown to the health departments. Ideally, there should be adequate facilities for every adult to have a free chest x-ray every year in his own community.

Treatment properly includes all aspects of supervision and guidance of the patient and his family from diagnosis through to recovery or fatal termination. This, then, involves supervision by the health officer and public health nurse; assistance to the family by social workers and welfare authorities; medical therapy; and the whole process of rehabilitation. As with other communicable diseases, an adequate local health department is necessary to conduct such a program.

Supervision of tuberculosis patients is possible only if there are public health nurses available to give this supervision. The public health nurse is the G.I. on the firing line. She must be directed by a competent officer, and there must be adequate community facilities for hospitalization of the tuberculosis patient and for assistance to his family. But the public health nurses are the combat troops who make or break a tuberculosis control program. It is estimated that about 5,000 more public health nurses are needed for even a minimum public health nursing program.

There is a serious shortage of tuberculosis hospital beds and there is also a serious shortage of the whole gamut of the army of personnel necessary to the smooth running of a tuberculosis hospital. From the standpoint of personnel and of newer developments in therapy, it is increasingly desirable to locate tuberculosis hospitals in proximity to medical centers in the city.

The public and the medical profession still have not accepted universally the fact that tuberculosis is a communicable disease and must be treated as a public health problem. Too often the means test is applied before a tuberculosis patient is permitted to enter a hospital and before welfare assistance is granted to his family.

Another obstacle to more rapid control of tuberculosis is the frequency with which patients leave hospitals against medical advice. Two factors seem to be responsible. The first is the matter of communities providing inadequate assistance to the family. The second factor is failure on the part of hospital personnel to consider adequately the personal and emotional problems of tuberculosis patients. Rehabilitation services are needed also to bridge the gap between the tuberculosis hospital and full employment. Another obstacle in the field of treatment is the lack of a completely satisfactory antibiotic or chemotherapeutic agent. Streptomycin and para-aminosalicylic acid combined have proved very helpful in certain types of tuberculosis. However, the tubercle bacillus readily develops resistance to it.

There are two main aspects to tuberculosis control through increasing resistance to tuberculosis. Probably, the most important factor in the non-specific category is adequate nutrition. There are still many people who lack or fail to utilize the modern knowledge of nutrition or are too poor to provide adequate nutrition for themselves and their families.

With regard to specific active immunization against tuberculosis, the only accepted vaccine available is BCG (Bacillus of Calmette-Guerin). The vaccine is safe and there is evidence that the vaccine is helpful as a supplement but it has definite limitations. There is great need for a better vaccine—one which may be given to everybody; one which is not only safe but without severe reactions; preferably one consisting of killed micro-organisms; and one which produces a solid immunity.

All of the obstacles mentioned indicate the need for further research concerning all aspects of tuberculosis—further clarification of its epidemiology; better methods of health education and motivation; increased knowledge of the psychiatric problems of the tuberculous patient and his family; better methods of medical and surgical treatment; improved programs of rehabilitation; the development of a better anti-tuberculosis vaccine; and more precise knowledge of the tubercle bacillus itself—its genetics, physiology, chemical composition, and immunological properties of its various chemical components.

The present world crisis is a threat to the eradication of tuberculosis, as well as to every other ideal of the free peoples of the world. Millions of our citizens will have intimate contact with others all over the globe in the years to come, including areas of very high prevalence of tuberculosis. Such mixing will be on an unprecedented scale and will occur through troop movements, the program of technical assistance to backward areas, through service in the diplomatic corps, and in commercial ventures.

In spite of the uncertain days ahead, there is reason to believe, however, that eventually the obstacles besetting the free peoples of the world, as well as the obstacles in the control of tuberculosis, will be overcome and we shall finally see the day when the dreadful and unnecessary scourge of tuberculosis is a thing of the past.

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All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast.... Something hot is cheering and tones up the whole digestive route."

The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

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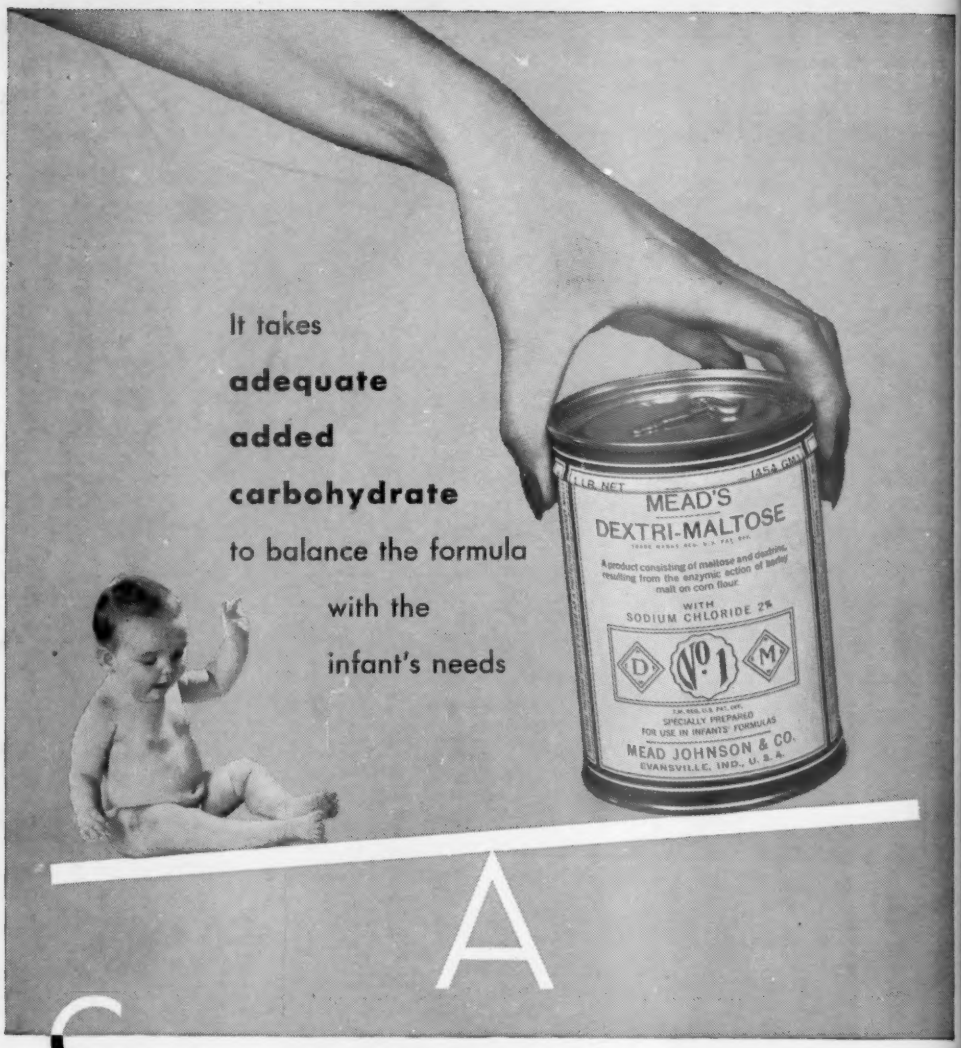
FAT	10.5 Gm.	COPPER	0.2 mg.	VITAMIN C	10 mg.
CARBOHYDRATE	22 Gm.	VITAMIN A	1000 I.U.	VITAMIN D	140 I.U.
CALCIUM	370 mg.	VITAMIN B_1	0.39 mg.	CALORIES	225
PHOSPHORUS	315 mg.	RIBOFLAVIN	0.7 mg.		

*Based on average reported values for milk.



Cow's milk traditionally supplies protein needed for the infant's growth and development. But to "spare" all this protein for its essential tissue-building functions, generous amounts of carbohydrate are needed—more than are provided by the milk alone.

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